ADMITTING PRACTICES IN VA MEDICAL CENTERS AND THE QUALITY OF SERVICE RENDERED BY THE VA REGIONAL OFFICE IN TENNESSEE

HEARING

BEFORE THE

SUBCOMMITTEE ON
OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

NINETY-SEVENTH CONGRESS

SECOND SESSION

MARCH 22, 1982

Serial No. 97-55

Printed for the use of the Committee on Veterans' Affairs

U.S. GOVERNMENT PRINTING OFFICE
93-420 O WASHINGTON : 1982

H761-19

COMMITTEE ON VETERANS' AFFAIRS

G. V. (SONNY) MONTGOMERY, Mississippi, *Chairman*

DON EDWARDS, California
JACK BRINKLEY, Georgia
RONALD M. MOTTL, Ohio
ROBERT W. EDGAR, Pennsylvania
SAM B. HALL, Jr., Texas
DOUGLAS APPLEGATE, Ohio
MARVIN LEATH, Texas
WILLIAM HILL BONER, Tennessee
RICHARD C. SHELBY, Alabama
DAN MICA, Florida
THOMAS A. DASCHLE, South Dakota
BOB STUMP, Arizona
PHIL GRAMM, Texas
AUSTIN J. MURPHY, Pennsylvania
BYRON L. DORGAN, North Dakota
ANTONIO B. WON PAT, Guam

JOHN PAUL HAMMERSCHMIDT, Arkansas
MARGARET M. HECKLER, Massachusetts
CHALMERS P. WYLIE, Ohio
ELWOOD HILLIS, Indiana
HAROLD S. SAWYER, Michigan
GERALD B. SOLOMON, New York
JIM JEFFRIES, Kansas
BOB McEWEN, Ohio
JIM DUNN, Michigan
CHRIS H. SMITH, New Jersey
ALBERT LEE SMITH, Alabama
DENNY SMITH, Oregon
MARK D. SILJANDER, Michigan

MACK FLEMING, *Chief Counsel and Staff Director*

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

G. V. (SONNY) MONTGOMERY, Mississippi, *Chairman*

GEORGE E. DANIELSON, California
BOB STUMP, Arizona
SAM B. HALL, Jr., Texas
DAN MICA, Florida
MARVIN LEATH, Texas
ANTONIO B. WON PAT, Guam

ELWOOD HILLIS, Indiana
JOHN PAUL HAMMERSCHMIDT, Arkansas
HAROLD S. SAWYER, Michigan
GERALD B. SOLOMON, New York
JIM JEFFRIES, Kansas

CONTENTS

Page

Admitting practices in Veterans' Administration medical centers and the quality of service rendered by the VA regional office in Tennessee 1

STATEMENTS BY MEMBERS OF CONGRESS

Chairman Montgomery 1

Hon. Robin Beard 2

WITNESSES

Arnett, Herbert S., director, Veterans' Administration Medical Center, Memphis, Tenn 4

  Prepared statement of Mr. Arnett 47

Snelling, Joseph C., director, Veterans' Administration Medical Center, Mountain Home, Tenn 12

  Prepared statement of Mr. Snelling 48

Deters, Larry E., director, Veterans' Administration Medical Center, Nashville, Tenn 14

  Prepared statement of Mr. Deters 49

Pepiot, Robert S., director, Veterans' Administration Medical Center, Murfreesboro, Tenn 16

  Prepared statement of Mr. Pepiot 52

Roden, William H., commissioner, Tennessee Department of Veterans' Affairs 22

  Prepared statement of Mr. Roden 55

Whitten, B. H., commander, Department of Tennessee, Disabled American Veterans 25

Jackson, Dan W., president, Vietnam Veterans Association 27

  Prepared statement of Mr. Jackson 57

Doten, David, past commander, Department of Tennessee, Veterans of Foreign Wars 28

Lollar, Ron, county service officer, Shelby County, Tenn 32

Bielak, Robert S., director, Veterans' Administration Regional Office, Nashville, Tenn 36

  Prepared statement of Mr. Bielak 59

ADMITTING PRACTICES IN VA MEDICAL CENTERS AND THE QUALITY OF SERVICE RENDERED BY THE VA REGIONAL OFFICE IN TENNESSEE

MONDAY, MARCH 22, 1982

House of Representatives,
Committee on Veterans' Affairs,
Subcommittee on Oversight and Investigations,
Memphis, Tenn.

The subcommittee met, pursuant to notice, at 9:30 a.m. in the Memphis City Council Chambers, 125 N. Mid-America Mall, Memphis, Tenn., Hon. G. V. Montgomery (chairman of the subcommittee) presiding.

Present: Representatives Montgomery, Hall, Hillis, and Beard.

OPENING STATEMENT OF CHAIRMAN MONTGOMERY

Mr. Montgomery. Good morning. The Subcommittee on Oversight and Investigations of the House Veterans' Affairs Committee will come to order in Memphis, Tenn., on the mighty Mississippi River. I would like to welcome our guests this morning. As far as I know, this is the first time in many, many years that the Veterans' Affairs Committee of the House of Representatives has asked for testimony in this part of our Nation.

I would first like to say that we are very fortunate to have with us the Chairman of the Subcommittee on Compensation, Pension and Insurance of the Committee on Veterans' Affairs, the Honorable Sam Hall of Texas, who is on my left. I appreciate Congressman Hall being here.

In just a few minutes the ranking minority member of the subcommittee, the Honorable Bud Hillis of Indiana, will be here. He is flying in and he will be here in just a few minutes.

And we appreciate the Honorable Robin Beard, who represents the Sixth Congressional District of the All Volunteer State, being here and we have asked him to sit with the subcommittee. I might say that Congressman Beard invited us officially several months ago to come to Memphis and have this hearing.

We are meeting this morning to receive testimony on admitting practices and the quality of health care delivered by the Veterans' Administration in Tennessee, as well as the quality of service provided by the Nashville VA Regional Office. We want to find out, as I mentioned earlier, about the Veterans' Administration nurse shortage, which has caused the closing of 800 hospital beds in VA hospitals in 1981. We want to find out if this has had any effect upon VA medical care in Tennessee.

We would also like to know the effects of budgetary constraints upon VA hospital admitting practices. We are concerned and want the hospital directors to tell us if they have adequate funds to help inpatient and outpatient veterans who come to their different hospitals.

We would like to find out about the quality of service provided by the Nashville VA Regional Office, which administers veterans' benefits for the entire State of Tennessee. I would like to make this point: The veterans in Tennessee, during 1982 and including fiscal year 1983, each year will receive over $285 million in compensation and pension benefits. You have well over 500,000 veterans in Tennessee and well over 150,000 of these are Vietnam veterans.

About $40 million in educational benefits will be coming into Tennessee. The Nashville VA Regional Office has the responsibility for the GI loan guaranty program, which helps veterans in obtaining homes. While there have not been a greater number of new home loans processed, the Nashville Regional Office has been busy assisting veterans who have fallen behind in their loan payments, trying to help these veterans having problems in meeting their monthly payments to not lose their homes.

Congressman Hall, we would like to hear from you any comments you wish to make about the hearing this morning.

Mr. HALL. Thank you, Mr. Chairman.

I, too, am looking forward to hearing testimony from the various organizations and people connected with these hospitals in this area. I know that the service is good. I have been familiar with it for a number of years prior to coming to Congress. I know that the service excels. There are situations which arise from time to time which might need some inquiries and I am just looking forward to discussing those problems with those people who are here.

Thank you.

Mr. MONTGOMERY. Thank you, Chairman Hall.

Before calling on Congressman Hillis, we will kind of let him get his—as they say in the Peabody—get their ducks in a row, I would like to call on Mr. Robin Beard who is from this Congressional District and who invited our committee to be here. Congressman Beard.

STATEMENT OF HON. ROBIN BEARD, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TENNESSEE

Mr. BEARD. Thank you, Mr. Chairman.

I would like to say that I requested this hearing today because, as a member of the House Armed Services Committee and as a Representative from Tennessee, I believe it is extremely important to explore fully the problems of the VA health care system with special focus on the Midsouth area.

I want at this time to express my deepest gratitude to you, Chairman Montgomery, and to my good friend from Texas, Sam Hall, and Bud Hillis from Indiana, for coming down and granting my request to hold a field hearing in Memphis, Tenn.

So I thank you all in a very sincere way.

Mr. Chairman, as members of the House Armed Services Committee, we both know of the direct link between military personnel issues such as recruiting and the adequacy of health care provided to those who serve and that are injured during that service. We cannot hope to recruit people into the military if we cannot assure them that they will be cared for if injured during their service. In my opinion, it has to be one of the most important responsibilities of this Federal Government to take care of the needs of those who have served their country and have experienced injuries as a result of that service.

So I am pleased that you did come down here. I feel that this is an appropriate place inasmuch as you have one of the most important medical centers here in the VA structure in Memphis, serving approximately 18,000 inpatients and approximately 160,000 outpatients annually. It is utilized by veterans from all over a multi-State area. It is also the location of the Spinal Cord Injury Center, a specialized treatment facility and therefore a logical place to explore the admitting practices of specialized centers.

I have heard and I look forward to hearing the testimony today that the VA medical care system in the country could be approaching a very serious problem with the World War II veterans reaching an age of declining health. We also have a new generation of veterans who served their Nation in a war that experienced a great deal of difficulty, Vietnam. We have a very serious responsibility to address those unique problems that have been experienced by Vietnam veterans. And I know the Congress and the VA and your committee has addressed those problems.

So I just want at this time to once again say thank you. I thank the witnesses who have taken the time to come down and for the jobs that they have performed in serving the veterans and I look forward to their testimony.

Mr. **Montgomery**. Thank you, Mr. Beard. You mentioned the VA Hospital here in Memphis, Tenn. I think when we have the Director of the Hospital that we should talk about the construction needs of the hospital. I know there are plans to build new spinal cord facilities and it is one of the key hospitals in the country for taking care of spinal cord injuries, which is probably one of the worst type of injuries that you can have from a military standpoint, to an individual and how it affects that individual.

Mr. Bud Hillis of Indiana, we especially want to thank you as a Member of Congress, a member of this committee, and as the ranking minority member of this Oversight and Investigations Subcommittee, for coming to Memphis, Tenn., from Indiana. You have a lot of problems in Indiana now as I understand it, that water coming out of Fort Wayne might be headed to your congressional district, so we are going to try to move these hearings right along and give you the opportunity to participate and hope you do not have to go back to Indiana this afternoon.

The Chair recognizes the gentleman from Indiana.

Mr. **Hillis**. Thank you, Mr. Chairman.

I, too, am very happy to be here. As far as that water, it may get down to this congressional district eventually, I do not know. There is a lot of it up there.

I just arrived on the secne and I certainly look forward to hearing the testimony here today. I appreciate very much the invitation of my colleague, Robin Beard, to come down and to sit in on these hearings because all of us are very concerned about the care of our Nation's veterans. From time to time we do get a chance to get out around different major hospital facilities and receive testimony from those who are administering the hospitals and those who receive the care, and I think we all learn something, I know I do, as a member of this committee, through these field trips.

I certainly look forward to hearing the testimony that we will be getting here today and again I want to thank my colleague, Robin Beard, who is one of the strongest forces in Congress, I think, when it comes to both Armed Services and care of the Nation's veterans.

Thank you, Mr. Chairman.

Mr. MONTGOMERY. Thank you, Congressman Hillis.

I will now call our first panel. I will call the panel up and then we will go through the ground rules. Our first panel consists of Mr. Herbert Arnett, Director of the VA Medical Center in Memphis, Tenn.; Mr. Joseph Snelling, Director of the VA Medical Center in Mountain Home, Tenn.; Mr. Larry Deters, Director of the VA Medical Center in Nashville, Tenn.; and Mr. Robert Pepiot, Director of the VA Medical Center in Murfreesboro, Tenn.

For the members of the subcommittee, we do have three more panels. This will be our largest panel. If there are no objections, we will operate under the 5-minute rule. We would also like for the witnesses this morning, if you can, to limit yourselves to oral testimony of 5 minutes and then after all of you have made a statement, then the subcommittee members will come back and make comments or questions.

Mr. Arnett, we will start with you, as the Director of the VA Medical Center here in Memphis.

STATEMENT OF HERBERT S. ARNETT, DIRECTOR, VA MEDICAL CENTER, MEMPHIS, TENN.

Mr. ARNETT. Thank you, Mr. Chairman, I want to thank this Subcommittee on Oversight and Investigations of the House Committee on Veterans' Affairs for the privilege of testifying today.

Also, I want to thank the committee for the continued support that we get in the Veterans' Affairs Committee of the House for veterans benefits.

In relation to the two subjects of this hearing, admitting practices and the quality of health care delivered by the Veterans' Administration in Tennessee, I will try to furnish a brief overview. The Memphis VA Medical Center admits approximately 18,000 veterans to inpatient care annually. We receive annually approximately 38,000 applications for care. Of this 38,000, approximately 76 percent are found in need of care and are either admitted to inpatient programs or placed in an ambulatory care clinic program. Our admission practices are administered as authorized for legal and medical eligibility by Congress. No legally eligible veteran found in need of care has been refused care at our medical center.

Our total facility capacity consists of 923 hospital beds. We are presently operating 883 hospital beds. We have a new 120-bed nursing home care unit which was activated on March 16 of last year. We also have administrative responsibility to serve the Memphis National Cemetery and the Corinth, Miss. National Cemetery.

We also have administrative responsibility for a Vietnam Outreach Center located in downtown Memphis. This center has four employees, three counselors and one clerical employee. The three counselors are former employees of our medical center.

We are assigned and funded for 705 average daily inpatients and 150,300 outpatient visits. We have averaged 713 inpatients the past month. The average number of outpatient visits for the last 3 years has been 158,688, which indicates that we are treating more outpatient veterans than our assigned workload. Non-service-connected or ambulatory care veterans, when stabilized, are referred back to the community for their health care. There are 245,000 veterans in our primary service area, which covers 19 counties in Tennessee, 25 counties in Mississippi, 8 in Arkansas and 1 in Kentucky. Our spinal cord injury service treats patients from throughout the Southeast and Southwest.

Since we have almost all of the subspecialty programs, we receive many referrals from outside of our primary service area, especially from southeast Missouri. When the Popular Bluff VA Center does not have the subspecialty to meet the veterans' needs, they are referred to our medical center for treatment. An example would be neurosurgery, drug and alcohol dependencies, open heart surgery and so forth.

We deliver quality health care to a large number of multidisciplined staff that offers numerous services to promote the well-being of the veteran patient. From a medical point of view, there are 77 board certified specialists representing a vast array of specialties. These specialists are responsible for a number of health care programs which significantly contribute to the health of the veteran. Open heart surgery, renal dialysis, geriatrics, alcohol and drug rehabilitation are but a few samples of the programs offered. The intensive care unit and nursing home care units are some of the finest units of their kind in the midsouth.

Affiliation of the Memphis VAMC with the University of Tennessee Center for the Health Sciences greatly increases the quality and amount of health care rendered to the veterans through the promotion of higher standards for patient care. Although the primary mission of this VAMC is quality health care to veterans, 1,400 allied and medical personnel received a significant part of their training through the various programs offered at this center. This, in turn, enriches the health care of the veteran.

In addition to the quality medical care administered at the Memphis VMC, a variety of other disciplines are provided. For example, social services, rehabilitative services, psychology, chaplaincy, hearing and speech pathology are provided to improve the veteran's health status.

A class II emergency room is provided to render acute care and less critically ill veterans are triaged by means of a multidisciplined health team to determine how best to meet the veteran patient's needs. This, many times, requires consultation which is provided by the appropriate subspecialties. We were accredited by the Joint Commission on Accreditation of Hospitals for 2 years this past December.

In order to carry out our assigned mission our recurring funds for fiscal year 1982 is $55,627,623 and our full time equivalency employee ceiling is 1985. Our per diem costs for fiscal year 1982 will be $191.83 per day.

We feel that the quality of health care delivered by the Memphis VAMC equals or exceeds any health care delivered within the Mid-south area.

Taking into consideration our budget constraints, we will continue to administer all programs in health care that are authorized by Congress.

And again, I want to thank you for letting us appear before this committee.

Mr. **Montgomery**. Thank you, Mr. Arnett.

I think since we are in the Memphis area, if there is no objection from the subcommittee, we will go ahead and question you while your testimony is fresh in our minds and then we will get to the other panelists, if they do not have any objection.

I am going to have several questions. Mr. Arnett, tell the subcommittee what building programs are now on the drawing board and update us in what construction is taking place at the Memphis VA Medical Center.

Mr. **Arnett**. Mr. Chairman, we are very fortunate here at the medical center with the support we have been receiving from Congress concerning construction. Just last week we had a groundbreaking ceremony for a $9 million Ambulatory Care and Research Building.

Our hospital was constructed for about 50,000 outpatients back in 1968. We are presently running from 150,000 to 160,000 visits, so this is very needed space. It will be a 28-months project.

Also, next fiscal year, probably in March of next year, we will begin construction of a $34 million Spinal Cord Injury Building. We presently have our spinal cord injury patients housed on the fourth, fifth and sixth floors of our facility, which is very threatening to those patients being above ground level in case of a disaster. So it is much needed space and this will provide the renovated space that they vacate for the needed areas for support clinics within our hospital.

Mr. **Montgomery**. Mr. Arnett, about the spinal cord patients, can they return home, can they be rehabilitated?

Mr. **Arnett**. Mr. Chairman, our average stay for spinal cord injured veterans in our hospital is only 90 days. We do rehab these patients. They are placed on a complete rehab program, they are taught to do their daily activities and then they are integrated back into the community with their own resources. A lot of the veterans even go back to jobs.

Mr. **Montgomery**. What States do you draw from on your spinal cord injuries?

Mr. **Arnett**. We serve spinal cord injured veterans throughout the Southeast and Southwest. There are only 16 centers, spinal cord injury centers, and we are one of the largest, we have 160 beds. Therefore, they are referred here all the way from Texas, all through the Southeast, even up into Illinois.

Mr. **Montgomery**. One other question. Explain briefly to the subcommittee about the Vet Centers, the storefront centers such as you have here in Memphis, Tenn., and I believe there are two others in the State, where the Vietnam veteran can come in and talk over his problems without having to go to the VA hospital here in Memphis. How is that working? Are Vietnam veterans coming in and what supervision do you have over these centers?

Mr. Arnett. At the present time our Vet Center has been activated for almost 2 years. We are proud to say that we are among the top 10 in the country in statistics. Those statistics are the number of patients we have served. Since activation over 2,200 Vietnam veterans have been seen and about 45 percent of those veterans have expressed concern over agent orange and are directed to utilize our medical center facility for evaluation and treatment.

Our present patient population at the medical center of Vietnam veterans is about 16 percent, inpatients.

Mr. Montgomery. You said they are concerned about agent orange, that is the main concern of the Vietnam veterans?

Mr. Arnett. That is not the major concern, that is a concern; the major concern has been in unemployment and at the present time approximately 80 percent of all veterans coming to the counseling center is seeking help in employment, to seek employment.

Mr. Montgomery. Thank you.

Mr. Hillis?

Mr. Hillis. Mr. Chairman, I do not have any questions at this time and I would like to yield if I might my time to Mr. Beard.

Mr. Montgomery. All right. Mr. Hall?

Mr. Hall. Mr. Arnett, you stated that the cost per patient per day is about $191 at your hospital?

Mr. Arnett. That is correct.

Mr. Hall. Is that above or below the national average?

Mr. Arnett. That is on the lower edge of the national average of VA facilities.

Mr. Hall. You mentioned also the spinal column, spinal area that you are concerned with. Also, in addition to veterans, I think that the people who may be in the armed services who have spinal problems are sent to this hospital, are they not?

Mr. Arnett. That is very true. Not only spinal cord injuries, but we receive in a lot of the subspecialties active military people who are referred to our facility for treatment. We have a large Naval installation here at Millington and we constantly treat their active duty patients due to the fact that they do not have some of the specialties.

Mr. Hall. When you have a soldier or a sailor who has received some type of spinal injury and a civil action, and a lawsuit ensues in which that person sues a third party that he or she may think responsible for their injury, is it the policy of the veterans' hospital to intervene in that suit and try to recoup any amounts of money that you have spent on that patient?

Mr. Arnett. Yes, sir. Any time there is a third party involved in an accident, we turn this over to our attorneys' office and they pursue this to collect for benefits received by the Veterans' Administration as part of the settlement of the suit.

Mr. Hall. What has been your experience, is that a successful practice?

Mr. Arnett. Those that we do pursue and settlements are made, we collect 90 percent of those.

Mr. Hall. Do you have any idea as to the dollar amount that you have collected in the past year?

Mr. Arnett. No; I do not. I do not have those figures.

Mr. Hall. Is it a sizable amount?

Mr. Arnett. I would guess we probably run about four per month, an average of about four cases a month that we collect from.

These funds are not kept locally, they go back into the Treasury.

Mr. Hall. All right.

I noticed that you show on your organization chart a 75 percent occupancy rate. Is that a rather high occupancy rate for the number of beds?

Mr. Arnett. We normally run about 78 to 79 percent occupancy rate and for very acute facilities with all the subspecialties that is about average for the VA.

Mr. Hall. The nursing care beds have a 45 percent occupancy rate.

Mr. Arnett. That is due to the fact of just activation, we only have 70 patients now of the 114 average daily census we will get once we are completely filled. We only opened one ward 2 months ago.

Mr. Hall. With the number of veterans of World War II who are reaching 60–65 years of age and with your occupancy rate 75 percent now, do you think that in the foreseeable future are you going to need more beds at the Memphis hospital?

Mr. Arnett. We do not feel we will need more acute beds. There may be a time in the future that we will need more intermediate type beds.

Mr. Hall. What is your occupancy rate now on the intermediate?

Mr. Arnett. We are running about 80 percent on the intermediate.

Mr. Hall. That is a little high on average, is it not?

Mr. Arnett. No; that is about average and in some extended care areas they run as high as 90 percent.

Mr. Hall. Do you think that you will have to have additional bed space within the next 5 or 10 years?

Mr. Arnett. No, sir, I do not anticipate the need for additional beds in the next 10 years.

Mr. Hall. All right. I think your testimony indicated that you are affiliated with the University of Tennessee.

Mr. Arnett. That is correct.

Mr. Hall. How is that working out?

Mr. Arnett. That attributes to the quality of the care that we have. All of our physicians that we recruit, we recruit them on the basis that they can qualify to receive an academic appointment at the University of Tennessee School of the Health Sciences. Therefore, we get much better qualified physicians.

Mr. Hall. You have had no problems with that?

Mr. Arnett. None whatsoever.

Mr. Hall. Now the committee has been concerned about appropriations for the medical and prosthetic research program for the past several years. As you know, the fiscal year 1982 appropriation is $128 million, which had a severe impact on the total VA research program.

Can you give us any details of how that is going to react or impact on your hospital?

Mr. Arnett. Yes, sir. The career development program, which is designed to recruit young physicians to develop their potential for academic medicine and retain them in the VA made no new appointments in fiscal year 1982. They did not fund any new programs, research projects, only the ongoing programs have been funded. If this action continues, we will not be able to recruit the young, active physician in the future.

Supplemental allocations have not been made for pay raises, which had to be absorbed, or increased benefit costs. Two percent of our local budget that are now committed to salaries had to go for the increase of the salaries. Now there are no local funds to meet emergency needs or to offset in any way the impact of the national funding restrictions.

Long range rational planning in both fiscal and programmatic is impossible and there is no special research program funding, including such as we would like to have, agent orange, alcoholism, rehabilitative engineers and so forth.

The impact has been, the bottom line is that we are continuing as we are with the programs that we have. No progress.

Mr. Hall. Thank you very much. I yield back the balance of my time.

Mr. Montgomery. Thank you, Chairman Hall.

Mr. Beard?

Mr. Beard. We have been discussing in Congress and I think Senator Percy has been one of the people that made his interest known that possibly because of the shortage of military doctors on active duty, because they are not able to provide medical care to the dependents of active duty personnel, there has been a debate and a discussions as to using VA hospitals to fill that void, to treat dependents of active duty personnel.

Would you be able to absorb that type of influx or how would that affect—what type of impact would that make on you?

Mr. Arnett. Congressman Beard, I feel it is appropriate to treat the active duty patients themselves. We would not have the resources, space or staff availability to treat the dependencies of those people at the present time, primarily due to the type staff we have. We have no gynecologists, OB's and so forth. But it would be appropriate to take care of those veterans, which we do now, those active duty people.

Mr. Beard. Do you see a great deal of duplication, or is there as to sophisticated pieces of equipment that are maintained at Millington and that same type of equipment being maintained at the veterans hospital, that some duplicity could be eliminated?

Mr. Arnett. That is very possible. I would think as close proximity as we are that we try to share. They do receive quite a bit of support from us, especially in the laboratory areas. But the major problem I think that they have is getting the people to operate the equipment that they have in the subspecialties.

Mr. Beard. Would you say, in your opinion, in dealing with the situation at Millington, would you say that the shortage of physicians and medical personnel on active duty is an extremely critical problem?

Mr. Arnett. Yes; it is, very much so.

Mr. Beard. And I do not think they have faced up to it yet. I do not think this active duty military—I think they have literally participated in a—almost a coverup as to their lack of honesty with the committee in describing just the urgency of it. I talk to other people in related fields such as veterans' hospital and administrators and they all substantiate what we know, but for some reason, the civilian leadership in the Pentagon will not come over and be honest with us. And hopefully one of these days we can find that honesty.

Let me ask you real quickly too, nurses, what kind of shortage are you experiencing here in the Memphis area?

Mr. Arnett. This is very much of an impact. There are 8,000 beds in the medical complex in the Memphis metropolitan area, very competitive, very competitive on good qualified nurses for recruitment. As fast as we train real good nurses, since we are on a pay scale that is set by Congress, we can only pay a certain level to a qualified nurse, the private sector can recruit those nurses away from us with more of a monetary need.

Right now, we have five beds closed in our critical care unit, SICU, MICU and surgical intensive care unit, due to the lack of qualified nurses.

Mr. Beard. Are there any rules or regulations that have been established in the VA bureaucracy that remove some flexibility from your hiring procedures on nurses? I know in the Reserves there was something about what type of degree or where they got their nursing degree or something like that.

Mr. Arnett. There is no restriction on the recruitment; there is a restriction on how much we can pay that is legislated; based on their training and experience they fall in a certain pay scale.

Mr. Beard. So really we might be——

Mr. Arnett. We are not competitive right now, sir.

Mr. Beard. We are preaching the point then of diminishing returns as to spending hundreds of millions of dollars in capital outlay or outlay for construction for new beds, but if we are not prepared to maybe adjust as to the nurses' salaries, why have the new beds because you are not going to have anybody to service them.

Mr. Arnett. We do have a provision where we can have a higher entry level for new graduate nurses coming into our program, but after they stay 6 months to a year and receive some training, they will leave us to go to a higher paying job. This is especially true in our critical care area where they have to receive a lot of additional training. They stay with us for a short period and they are recruited at a much, much higher salary. I feel that we have got to look at some more monetary rewards, especially for nurses working in critical care areas.

Mr. Beard. Thank you.

Mr. Montgomery. Will the gentleman yield—well, thank you. Let me just follow up on your question. We have implemented a new law that has been signed by the President that gives discretion to the Veterans' Administrator and to the hospital directors to adjust nurses' salaries. Also we have implemented a program that will be funded this year that will help educate student nurses. If we educate them, say 4 years, then they will have to give us 4 years of service in the VA hospital. We think this is going to help us get nurses in our VA hospital facilities and will improve the situation.

Mr. Beard. May I ask on that? Just how far out of the ball game are we in competing with Baptist or Methodist or some of the private institutions? How much money are you talking about—$100 extra a month; are you talking about $200? How far out of the ballpark are we?

Mr. Arnett. It is not always the money, Congressman. A lot of times it is the other type fringe benefits such as child care, parking, things of this nature, selection of tours of duty which we do not have the flexibility that they have in the private sector. Like the chairman just indicated, we hope that the new program that has been authorized by the omnibus bill will help us retain—we do not have the major problem recruiting as we do retaining after they have been in our system.

Mr. Montgomery. Thank you.

Mr. Beard, no way can we compete with the Baptists and Methodists—you ought to know that. [Laughter.]

Mr. Hall. Mr. Chairman, may I ask one followup question?

Mr. Montgomery. Yes.

Mr. Hall. Mr. Arnett, I know, being a member of the Immigration Subcommittee on the House Judiciary Committee, we are working with foreign nurses now for private hospitals, in the private sector. Of course, there is a shortage of nurses all over the United States, not only in your area but for private hospitals as well. I am sure Frank Groner would like to get more nurses if he could get them at Baptist.

I know the nurses in the Philippines and Great Britain are anxious to come over here if they can get the proper visas to come—would a foreign nurse program help you in any way?

Mr. Arnett. If they were qualified nurses, it would be the same to us as if they were a graduate of our local school. However, they do have to meet an English proficiency requirement.

Mr. Hall. I understand that.

Mr. Arnett. If they are not trained in an English school, then they have to take a test and pass it. This would probably restrict the group that would be coming over.

Mr. Hall. Well, I know that Rod Bell of the Presbyterian Hospital in Dallas has had a program going for some time getting nurses from Great Britain. It has been very successful. They have gone through all the tests and passed those tests, gotten the proper visas, and they are working out fine.

If that sort of program could be instituted, after getting Government approval—of course, it would take statutory action to do that—would they fit into your program?

Mr. Arnett. There is no question but what they would fit into our program if they are qualified nurses.

Mr. Hall. Are those nurses who are in the private sector now from a foreign country, are they doing a good job?

Mr. Arnett. No problem whatsoever.

Mr. Hall. Thank you.

Mr. Montgomery. Thank you very much, Mr. Arnett.

[The prepared statement of Mr. Arnett appears on p. 47.]

Mr. Montgomery. Mr. Snelling?

STATEMENT OF JOSEPH C. SNELLING, DIRECTOR, VA MEDICAL CENTER, MOUNTAIN HOME, TENN.

Mr. Snelling. Mr. Chairman and members of the subcommittee and Congressman Beard, I appreciate the opportunity to add my comments to those of my colleagues.

Mountain Home is rather unique. We are one of five Teague-Cranston Medical Schools, and I would like to spend most of my time talking about the quality of care and the impact of that medical school on us.

Since 1977, there have been significant changes in the quality of health care at Mountain Home as well as the method by which that medical care is delivered. In the fall of 1977, the Quillen-Dishner College of Medicine of East Tennessee State University admitted the first class of 24 students, as permitted and authorized by the Teague-Cranston Act.

Shortly before that time, the medical school began the process of recruiting a faculty of outstanding physicians who for the most part devoted at least part of their time to the care of veterans at the VA Medical Center at Mountain Home. This growth in the professional staff has continued until we presently have 55 full and part-time physicians on our staff. These academically oriented physicians have added new dimensions in specialized treatment such as gastroenterology and cardiology and infectious disease, neurology, opthalmology and others. This specialized care was not available at Mountain Home prior to 1977. In addition, we have presently 23 residents in post graduate training at Mountain Home in general surgery and internal medicine, as well as fellowships in cardiology and gastroenterology. These numbers will increase to 39 in July of 1982.

In part, the improved quality of care now being delivered at Mountain Home is reflected in the expanded scope of our services as I just described; however, we also point with a great deal of pride to some other generally accepted indicators of quality such as the full accreditation received from the Joint Commission on Accreditation of Hospitals. Incidentally, we just finished last week our 2-year review by the Joint Commission on Accreditation of Hospitals and last Friday the summation conference indicated a nominal amount of deficiencies and in our judgment we will continue our accreditation.

Our laboratory and pathology services are also fully accredited by the College of American Pathologists, making it the only such service in the tri-cities to receive accreditation from the College of American Pathologists.

In addition, our facility is surveyed biannually by a team from our central office as part of a systematic external review program. Our most recent SERP visit occurred in May 1981 with good results.

These agencies and bodies review not only programs but also physical facilities, and while we are proud of the overall outcome in each instance, we are certainly not without deficiencies, many of which are physical and structural in nature.

Most, but not all, of our physical plant deficiencies will be corrected by construction now underway or contemplated, and I would like to now present a brief description of the major construction projects at Mountain Home. I should preface these remarks by saying that all buildings on the grounds at Mountain Home are listed on the National Registry of Historic Places, since most were erected in 1903 and none were built after 1938.

All of these buildings are beautiful, in fact, but certainly inadequate for the practice of modern medicine. Because of already existing fire and safety deficiencies as well as the absence of adequate patient privacy—our wards are the open bay type—we feel that current facilities will not support medical care needs in the near or distant future. Consequently, a $10.6-million clinical support building containing 90,000 gross square feet and six new X-ray rooms, five operating rooms, seven surgical recovery rooms, new sterile supply facilities, and several outpatient examining rooms as well as a new laboratory suite is now under construction with completion anticipated in 1984.

Also now under construction with an anticipated completion date of 1983, is a medical school classroom building which will offer office space, biophysics laboratory, and medical school library for a cost of $13 million.

Neither of these buildings will contain facilities for patient occupancy and, as a result, the problems associated with patient privacy and logistics due to our multibuilding institution will not be resolved.

Most of our recent success can be attributed to the infusion of significant funding increases. This year, in fiscal year 1982, an additional $1.3 million was provided to Mountain Home over and above the usual increases for inflation and increased usage. These additional funds were provided by our central office after a comprehensive review of our needs and financial status in January of 1980. These funds were awarded primarily in recognition of the inevitable cost increases associated with a medical school affiliation and the resultant broadening of scope in treatment, education and research.

Increased drug costs, laboratory and X-ray utilization, expansion and use of more sophisticated diagnostic procedures, such as CT scans and nuclear medicine tests also had a significant impact on operating costs. These explosive increases are closely related to the growth of the Quillen-Dishner College of Medicine. Further expansion and development is logical and expected since the college has not yet reached its full potential of 72 students per class.

We also expect further growth of our own capabilities at the VA at Mountain Home to allow us to fully support the medical school. For example, we have intentions of developing a state-of-the-art surgical recovery room commonly associated with an up-to-date medical center. Our recovery room is presently staffed with only one nurse and operates 8 hours per day 5 days a week. This is about half of the staffing time needed.

We have recently activated a nuclear medicine service. However, in order to realize our full patient care and teaching potential and research capabilities, we must develop new treatment capabilities such as a cardiology step down unit, neurosurgical capability, as well as dermatology and gerontology specialties. These additional direct medical care support units will not come cheaply and while I know that our list of needs seems endless, it is because we have a great deal of ground to make up in an attempt to provide the veterans in our primary service area modern medical care and to reach parity with the long-standing medical school affiliations enjoyed by other VA Medical Centers in Tennessee.

Due in great part to our association with the Quillen-Dishner College of Medicine, our medical center has evolved from a bandaids and bruises primary care facility to a secondary care facility which is on the verge of becoming a tertiary state-of-the-art medical center with a vast array of medical and surgical specialties and subspecialties.

Essentially our admitting practices are the same as all VA Medical Centers because we are governed by laws established by Congress and VA regulations issued as a result of those laws.

An applicant for admission to our facility must meet the legal and medical requirements, the applicant is provided a thorough medical evaluation to determine his or her medical needs.

There are those instances wherein the nonservice-connected applicant is ill but not to the degree that the physician feels hospitalization will result if left untreated. When this occurs, the patient is not offered treatment of any kind, but is seen by a social worker who attempts to resolve the applicant's problems through community resources.

In recent months we have found that many veterans who have not heretofore used our facilities are now doing so. This we attribute to the general economic climate and unemployment in particular, in upper east Tennessee.

In summation, it is our continuing policy to provide all eligible veterans with prompt and compassionate and high quality medical care.

I appreciate again this opportunity to speak to the subcommittee and I will attempt to answer any of your questions, Mr. Chairman.

Mr. MONTGOMERY. Thank you, Mr. Snelling, I think we will wait on the questions, and your full statement will be put in the record.

[The prepared statement of Mr. Snelling appears on p. 48.]

Mr. MONTGOMERY. Mr. Deters.

STATEMENT OF LARRY E. DETERS, DIRECTOR, VA MEDICAL CENTER, NASHVILLE, TENN.

Mr. DETERS. Thank you, Mr. Chairman, members of the subcommittee, Congressman Beard.

I appreciate the opportunity to appear before the committee to discuss the quality of care and the admitting practices of the Nashville VA Medical Center. It is the goal and mission of the medical center to provide quality health care to all eligible veterans in accordance with existing law and regulations. Applications for care are processed in accordance with the priorities as mandated by 38 U.S.C. and the Veterans' Administration.

During recent years, there have been increasing demands on this medical center. It is my belief that some of the factors creating these increased demands include, first of all, a 16-percent population increase in middle Tennessee since 1970; a very high unemployment rate averaging 12 percent across the State and in some counties as high as 40 percent in our primary service area; and the increasing age of the veteran population which results in more complex care and more frequent health care needs. During the year the number of new applications per day has tripled. These veterans have never before applied for care at this medical center and many of them have never applied before to the VA. Most of them have lost their employer paid health benefits when they were laid off and their only other option was to come to the VA.

In spite of budget constraints, our statistics for 1981 showed that of a total of 24,971 applications received, 22,395 or 93.9 percent did receive treatment. We had the highest community nursing home census since the inception of that program in 1974; an increased turnover rate of 307.4 percent; a 79 percent occupancy rate and a reduced length of stay of 14.9 days. Outpatient visits to our medical center have continued to increase because of the health care needs of our veterans. During 1981, there were 135,101 outpatient visits to this medical center and our outpatient clinics in Knoxville and Chattanooga.

The quality of our professional staff is outstanding. Our physician staff of 74 includes 56 with faculty appointments and 55 of our physicians are board certified. Our nursing staff includes 23 nurses prepared at the master's degree level and 62 with baccalaureate degrees. A total of 38 nurses have special certificates in areas such as critical care, dialysis, operating room, emergency department and adult nursing. In addition to our medical residency program, we have allied health students from 38 colleges and universities. At the present time, we train approximately 87 students from these programs. These training programs assist us in maintaining an active and effective hospital and stimulate our own staff to maintain high standards of care. Despite our active role in medical and allied health education and research, our main objective is high quality patient care.

We provide a wide range of specialized medical programs, including open heart surgery, kidney transplantation, dialysis, alcohol abuse, cardiac catheterization, nuclear medicine, plus our intensive care unit capabilities. The satellite outpatient clinics in Chattanooga and Knoxville enhance referral patterns from these communities. And we do have the Outreach program in Knoxville as well.

In my opinion, there is a high quality of care provided at the Nashville VA Medical Center by a very professional staff. The care is continually monitored through a sophisticated quality assurance program which is totally supported by the medical staff. In addition, we require systematic internal review by every service in the medical center on an annual basis.

Since 1980, we have had three external reviews. These include the Joint Commission on Accreditation of Hospitals in December of 1980, which resulted in a full 2-year accreditation; a systematic external review program in September 1980, which resulted in all services being rated as good, very good and excellent; and an American Legion field visit in 1981, which described the support services as excellent and concluded that good patient care is being provided.

Thank you again for the opportunity to appear before you today.

[The prepared statement of Mr. Deters appears on p. 49.]

Mr. MONTGOMERY. Thank you very much.

Mr. Pepiot.

STATEMENT OF ROBERT S. PEPIOT, DIRECTOR, VA MEDICAL CENTER, MURFREESBORO, TENN.

Mr. PEPIOT. Thank you, Mr. Chairman, members of the subcommittee.

I am happy to be here to testify on behalf of the Veterans' Administration Medical Center, Murfreesboro, Tenn. I have two attachments that were made to my testimony. This is background information pertaining to our medical center. Attachment 1 is our admitting policy which follows all the regulations administered by Congress. And attachment 2 is a copy of our mission statement which describes our geographic area and thet ypes of patients served and treated.

Circumstances affecting our ability to provide care are as follows: On September 1, 1980, we were required to close buildings 5 and 6 for modernization which included fire and safety and patient privacy requirements. Total loss of operating beds in the two buildings was 138. This happened at a time when we were running above 90 percent occupancy, and thus, approximately 125 veterans were affected. To relieve the bed crunch at that time, veterans who could benefit were placed in residential care homes; others were placed in community nursing homes; and others were transferred to VA Medical Centers in Lexington, Ky.; Tuscaloosa, Ala. and Augusta, Ga. From September 1980 to mid-1981 this hospital was only able to admit emergencies.

On April 1, 1981, ward 6G was closed because of the demolition that was underway on the floors above. This further compounded our problem with availability of beds. Ward 6G since has become operational on February 1, 1982.

Murfreesboro is scheduled for additional building closures for modernization and to meet compliance with patient privacy and fire and safety. Our operating beds during this time will be limited to approximately 550. This will run through fiscal years 1983 and 1984. In fiscal 1985, buildings 3 and 7 should be operational and the fire and safety project in buildings 1, 8, and 9 should be completed. Beginning in fiscal year 1986, a new 120-bed nursing home care unit should become operational. In early 1986 or early 1987, we should be operating at a 730-bed level with a 120-bed nursing home care unit.

The quality of care administered at this medical center, I believe, is highly satisfactory. We have been able to augment our medical staff with board certified physicians. We currently have 11 board certified physicians, 5 in psychiatry, 2 in medicine, and 4 in other categories.

The outpatient services have also been upgraded and we currently have 11 clinics which provide a well-rounded program to meet the needs of the veteran and the patients that we serve. The outpatient clinics are relatively new at our facility, some having been started in fiscal year 1981 and others in early 1982.

We have two funded psychitary resident positions. In addition, we have four medical residents furnished by Meharry Medical College, with whom we have affiliation. This medical college is located in Nashville, Tenn. We also have approximately four medical students on any day during the week. All of this has helped to upgrade the quality of care that is delivered at our facility.

The mental hygiene clinic, which is an outpatient program, has also been effective in maintaining our patients in a community setting. We have a board certified psychiatrist who heads this program.

The residential care program is a very large one at our facility. We have veterans placed in 49 homes for a total of 316 veterans being served in this program. All of these homes are within a 75-mile radius of our hospital. This is an extensive program administered by our social work service. All homes are inspected by the State as well as by the Veterans' Administration. The average age of the veterans placed in this program is 69.2 years. Consequently, there are increasing medical problems which impact on our medical center.

The contract nursing home program currently in operation is funded for 33 placements. The VA, in the past, has contracted for 6 months; then, prior to expiration of that contract, the State medicaid program assumes responsibility for the family. Our ability to place beneficiaries in community nursing homes will be seriously jeopardized if the State medicaid program resources dwindle. Another problem associated with the contract nursing home program is locating a contract nursing home near the family because of the demand for such beds in the State of Tennessee. There will be increasing pressure to return the veteran beneficiary to an intermediate care bed as State resources decrease and demand for beds increase.

Thank you very much.

Mr. MONTGOMERY. Thank you, sir. Your entire statement will be made a part of the record.

[The prepared statement of Mr. Pepiot appears on p. 52.]

Mr. MONTGOMERY. Without objection, the Chair will shift around the panel and maybe get our veterans organizations who are represented here, so our panelists from the hospitals, from the departments of State government and also the regional office can maybe answer some questions that might come up in the discussion.

But thank you, gentlemen, and let me maybe just ask one question. Mr. Roden, in his statement as commissioner of the Tennessee Department of Veterans' Affairs, who will testify later, states that certain nonservice-connected disabled veterans are denied over-the-counter drugs. Will you please tell the committee what type of drugs these are and how the classification says that these over-the-counter drugs are not covered.

Mr. Snelling.

Mr. SNELLING. Over-the-counter drugs refer to drugs that do not require a prescription, like vitamins and similar drugs. As I recall, Mr. Chairman, that was part of a law that Congress passed eliminating that eligibility, as I recall, that nonservice-connected veterans—I could be wrong on that, but the over-the-counter drugs does refer to the nonprescription drugs.

Mr. MONTGOMERY. Mr. Deters?

Mr. DETERS. I might need to wait to hear what Mr. Roden meant in his comment, but over-the-counter drugs are those things such as vitamins. Nonservice-connected veterans who were not found to be in need of hospitalization or whose condition has stabilized may not be provided drugs under the law. If that is what they are referring to, that is not just over-the-counter drugs. Over-the-counter drugs are those that are needed without prescription.

Mr. Montgomery. Mr. Pepiot, do you wish to comment?

Mr. Pepiot. Well, I have to go along with what my colleagues have said. The over-the-counter drugs are usually those drugs that do not require a prescription. Second, as Mr. Deters stated, as a veteran who is on an outpatient basis is no longer found to be in need of that program, the drug program is cut off if he is not service connected.

Mr. Montgomery. Briefly, and this will be my last question and I will start with you, Mr. Pepiot, and moving down to the other two. What is the nurse shortage in your hospital?

Mr. Pepiot. I guess I am one of the few in Tennessee and in the Nation that is really not affected by that current shortage. We have an affiliation program with four nursing schools in our communities and we have a ready supply of nurses coming from those programs.

Mr. Deters. I would have to agree with Mr. Arnett's comments, our problem has not been in recruitment as much as it has been in retention. Last year we ran a 19-percent turnover in our nursing staff. This year it is ranging very close to 23 percent, which means approximately one out of every four nurses on staff will leave during the year. And this, of course, creates a tremendous training problems. The impact of that shortage in my hospital is that last summer we had to close the coronary care units, the four beds in there and the four beds in the stepdown unit. We were able to recruit nurses but not of the type with the training to operate those special care units.

We spend a great deal of time training those people and have lost a good number of them just in the course of this year. Once they are fully trained and able to operate independently in a coronary care unit, they become a very valuable resource in the city. And the private sector hospitals, I think in Mr. Beard's comments, the private sector hospitals will be able, no matter what we seem to do, to increase benefits to our nurses and, of course, they can always increase benefits one step beyond that. So there is a little bit of a treadmill in the hospital community as soon as nurses become short.

Mr. Montgomery. Mr. Snelling.

Mr. Snelling. Mr. Chairman, Mountain Home is not affected by a nurse shortage. As of the 16th of March, we had five vacancies and those were all committed. East Tennessee State University produces a class of degree nurses every June and we recruit heavily in that class because we are affiliated with that nursing school. We do not have any problems in retention or recruitment.

Mr. Montgomery. Thank you. Mr. Hillis?

Mr. Hillis. Thank you, Mr. Chairman. I would just like to address one general question to the panel. First of all, I know each of your situations are different. One gentleman testified about construction projects closing active beds, but I wondered if the patient population is such that you have any waiting list. Are you meeting the needs of the veteran population of the Tennessee community? Where do we stand there? Mr. Arnett?

Mr. Arnett. Congressman Hillis, we have no inpatient waiting list. We are taking care of all the veterans on the inpatient program. However, in the outpatient program, we do review those veterans who are stabilized after 60 days and if they are found to be stable and only need medication or a diet, then we refer those back to the community. We do not have the resources to care continually for the nonservice-connected veteran on an outpatient basis.

Mr. **Hillis**. On an outpatient basis.

Mr. **Arnett**. But no problem inpatient.

Mr. **Hillis**. Thank you. Mr. Snelling?

Mr. **Snelling**. The same at Mountain Home. We do not have any waiting list at all, Congressman.

Mr. **Hillis**. So you are meeting the needs for inpatient. How about the outpatient situation?

Mr. **Snelling**. Our physicians discharge the patient from the outpatient rolls as soon as the patient is stabilized. We again do not have the funds to maintain them indefinitely on an outpatient basis so it is only during their acute phase and followup after hospitalization. But we have no inpatient waiting list at all.

Mr. **Hillis**. Mr. Deters?

Mr. **Deters**. Yes. We have no inpatient waiting list and our outpatient procedure is the same as both my colleagues.

Mr. **Pepiot**. We felt that it was not necessary to create a waiting list because it was something that we could not fill anyway. Our beds at one time ran over 100 percent in our—as we were trying to come down in the closing of the buildings. We do have a waiting list for our nursing home care unit.

Mr. **Hillis**. And you are referring your patients, as you testified, to other facilities outside your area?

Mr. **Pepiot**. That is correct.

Mr. **Hillis**. And once your construction is completed, do you feel you will be meeting the needs of your service area?

Mr. **Pepiot**. Yes, I do.

Mr. **Hillis**. Thank you.

Mr. **Montgomery**. Mr. Hall?

Mr. **Hall**. Thank you, Mr. Chairman.

Maybe I am overly concerned about this high occupancy rate but the number of people are increasing that are coming in for treatment. I think one here is 84 percent—87 percent I believe, Mr. Pepiot, at your establishment, Mountain Home nearly 85, 84 percent, 83.4 and 74 percent at Nashville.

What would you do if you had an influx of veterans come into these hospitals with that high occupancy rate? I notice on one of these that you have, in Murfreesboro, 87 percent occupancy, maybe 88 percent, and a 95, nearly 96 percent occupancy in the nursing care beds.

Mr. **Pepiot**. That is true.

Mr. **Hall**. Is that not an awfully high rate? In my part of the country, I think that is an exceedingly high rate.

Mr. **Pepiot**. I think for an acute medical care center that would be a high rate. We are a long-term care, intermediate and psychiatry service, and that is not unusual for that high occupancy rate. I am very concerned when the crunch, so-called World War II crunch, hits us that our ability to readily serve the veteran is going to be impacted.

Mr. Hall. And you have what, about a 500-bed hospital now?

Mr. Pepiot. Five hundred and thirty bed hospital currently and when we are at full blast we will be at about 700, approximately.

Mr. Hall. Mr. Snelling, I am sure it is great to have everything listed on the National Register of Historic Places. It seems like it would have an adverse effect on the patients to be in a building that the latest one was built 43 years ago and all of the improvements you are making have nothing to do with bed care, but with the ancillary services that will go along with that. How do you propose to increase the number of beds—I understand they are all in more or less open bay areas now—what is your proposal to remedy that? I think that is a gross deficiency.

Mr. Snelling. I agree, Congressman Hall, it is a gross deficiency. In November of last year, the VA awarded contracts to an architectural firm in Nashville, Gresham & Partners, to develop what I refer to as a master plan or you might refer to as a 25-year construction plan. That proposal, that plan, is being furnished to the Administrator, Mr. Nimmo, hopefully this month. It contains three options. All three of those options contain a proposal to build a new 554-bed hospital. The difference in the options is the site on which that new hospital will be built. Tentatively priced at $180 million, the House Veterans' Affairs Committee will be faced with it sooner or later. I do not want to preempt the Administrator in his presentation, but the answer to your problem, as I see it, is a new hospital. You cannot make a modern hospital out of a building constructed in 1903. You just cannot do it.

Mr. Hall. It is impossible to do it.

Is there anything in the mill to try and replace that Mountain Home Hospital with a new facility at a different location?

Mr. Snelling. No. It is going to be built on the grounds. There are 205 acres there, most of which are open and available and all three options would include the building of a new hospital on the site of the present Mountain Home VA.

Mr. Hall. Well what do you admit primarily, what type patients do you admit at Mountain Home?

Mr. Snelling. A full range of patients. We are able to take care of any kind of problem that comes to us except neurosurgery and OB-gyn and pediatrics. We can handle anything else that comes to us other than that. And the way we handle neurosurgery is in the hospital next door to us that has seven neurosurgeons on staff. They do that work for us on a contract basis.

In other words, we can take care of any veteran that comes to our door unless it is an OB-gyn problem.

Mr. Hall. But there is no patient privacy at all in your hospital?

Mr. Snelling. Except that created by drapes around the bed, the curtains, privacy curtains around the beds. That is the only privacy.

Mr. Hall. Of course, that is not satisfactory.

Mr. Snelling. No, not really. There are a few private rooms in our surgical wards that we use for female patients, that is about half a dozen, and that is about it, Congressman.

Mr. Hall. What would be your recommendation? I appreciate all of you gentlemen's candidness with us, but of all the four that we have heard, I think you have got the biggest problem here of anybody with reference to facilities to take care of people.

What would be your suggestion, if you could wave the wand this morning: that is; in the area of fiscal sanity—do not go out the window with us. What would be the best way to solve many of your problems there, utilizing as much as possible your present facilities?

Mr. **Snelling.** Well in my judgment the best answer is a new hospital, a new high rise, patient occupied hospital. We have now under construction a new hospital, everything except the beds the patient sleeps on. The clinical addition has new operating rooms, new X-ray rooms, labs, everything in it that a new hospital has. The only thing we need is a high rise to house the patients in. And that is underway, that is being considered by the Administrator now and one of those three options is a $180 million 25-year construction plan that is being considered now, that Congress has not been asked to fund at this point. It is tentatively in my 5-year construction plan scheduled for 1984. Now obviously Congress has not considered that 1984 budget yet and I have to defer.

Mr. **Hall.** We cannot even get through the 1982 budget.

Mr. **Snelling.** I will have to defer to my Administrator, Mr. Nimmo, he is reviewing those plans now and I do not want to preempt his options, but he will be given three options by the Gresham & Partners in Nashville, the architects who are designing our master plan now under contract with the VA and hopefully he will select one of those three options.

And I think the answer is a new hospital.

Mr. **Hall.** Thank you.

Mr. **Montgomery.** Thank you, Mr. Hall. Mr. Beard?

Mr. **Beard.** One question, Mr. Deters.

The Department of Defense has gone and put together a plan for a case of an outbreak of hostilities let us say in the NATO scenario, as to providing for hospital beds for those injured that are flown back to the States. Have you worked with them in this process? What type of coordination has there been? What is going to be expected of your hospitals in case of an outbreak of hostilities and we do have a high influx of casualties? How will that affect the veterans service?

Mr. **Deters.** I have not had direct contact with the Department of the Army in the Nashville area, at least as far as I am aware. I have only been there about 7 months, so unless it happened prior to that. They were contacting private hospitals in St. Louis and some areas.

We have surveyed our staff to determine how many of our staff would likely be activated, placed on active duty, through their Reserve obligations and we would lose some of our staff which would reduce our capability somewhat.

We do not have a direct arrangement at this point to care for either injured military being flown in from overseas or their dependents. Fort Campbell is the closest military hospital to us and we have had some communication with them but not about this issue.

Mr. **Beard.** Any other people have any communication?

Mr. **Arnett.** Congressman Beard, our Memphis Medical Center has had contact. We met with the Millington Naval Air Base people, the commander of the hospital there is responsible for setting up a contingency plan with all the hospitals within this area, and we are part of that contingency plan. However, I understand there is legislation being proposed which will be coming out that will use the VA system as a backup for emergency military.

Mr. **Beard**. Thank you, Mr. Chairman.

Mr. **Montgomery**. That is one of the bills that I have the privilege—well I am the author of the bill. It has run into some problem in the Senate. It was our feeling in the Veterans' Committee and among veterans organiaztions that if we do get into combat and we have the beds available in the veterans' hospitals that, in effect we take care of our own. We were concerned that the armed services were going out and contacting these commercial hospitals or private hospitals and were not even checking with the veterans facilities, or about shared use of equipment which is very important. You mentioned today how you swap with Millington, and that also is in the bill, it would encourage sharing between the medical hospitals of the military and veterans hospitals.

I do not want to get in any trouble, but we are probably in better shape in the veterans' hospital facilities than the Army is. They have got some serious shortages of doctors and nurses. They depend on Reserves and the Reserves are not there in the medical resources, and they just need some help.

Thank you very much, panelists, you have been most helpful to us.

At this time, I would like to invite Mr. William Roden to come forward, who is the commissioner of the Department of Veterans' Affairs for the State of Tennessee; Mr. B. H. "Whitt" Whitten, Commander, Department of Tennessee Disabled American Veterans. Mr. Whitten was traveling all over the State and we finally ran him down. Mr. Dan Jackson, who is president of Vietnam Veterans' Association, State of Tennessee. Mr. Jackson, you got your statement in on time and we appreciate that. Mr. David Doten, we are familiar with you, you were former commander of the VFW for the State of Tennessee and now serve on the VFW National Legislative Committee. We know you had a case in court and you took time off from that situation to appear here this morning.

If we can have a summary of your statements, I believe this would help us a great deal.

Mr. Roden, we will start with you then and come right down the line the way you are lined up there and, again, thank you.

There are two gentlemen that I did not identify. Would you identify yourselves?

Mr. **Lollar**. I am Ron Lollar, I am with the Shelby County government, I am the veterans' service officer here in Shelby County.

Mr. **Montgomery**. Appreciate you coming.

Mr. **Holton**. I am Ira Holton, Tennessee Department of Veterans' Affairs, Memphis area.

STATEMENT OF WILLIAM H. RODEN, COMMISSIONER, TENNESSEE DEPARTMENT OF VETERANS' AFFAIRS

Mr. **Roden**. Thank you very much, Mr. Chairman, members of the subcommittee. I want to thank you for the privilege of appearing before the subcommittee. My name is William H. Roden. I am commissioner of the Tennessee Department of Veterans' Affairs. As a member of Gov. Lamar Alexander's cabinet, I wish to bring you the warmest greetings from our Governor and from the executive branch of State government and offer the services of my office to assist you in any way possible.

Also, I am the service officer for the American Legion Department of Tennessee, and as such today I represent State Commander John Maddox. Mr. Maddox called me and asked me to represent him at this hearing.

As commissioner, I serve and work with more than 542,000 veterans who currently live in Tennessee. My remarks will be directed toward what I perceive to be the major concerns of veterans in Tennessee with regard to the topics that you selected for this hearing. The VA medical center and the VA regional office in Nashville are in very good hands as far as management is concerned. I must emphasize the sensitive and responsive nature of the directors and the entire staffs of these units. My experience has been that any inquiry or suggestion from my office to them has been acted upon immediately. These actions have evidenced great concern for the veteran and the highest respect for ethical and professional standards.

Mr. Chairman, the admitting practices of all VA medical facilities, the centers and the clinics, in Tennessee insofar as I know appear to be consistent with the Veterans' Administration priority criteria for such admissions. However, the nonservice connected veteran under 65 years of age who is chronically ill must be denied admittance to a VA medical center in many cases. This problem is becoming a major concern for many veterans in Tennessee.

The quality of health care rendered by the VA in Tennessee is second to none. A very major concern has already been alluded to by the chairman, which is the concern over the abolishment of the over-the-counter drug program for the nonservice connected veteran patient.

And by this, Mr. Chairman, I am referring to the type of drug that would take care of diabetes, high blood pressure, certain types of cancer, glaucoma and other conditions of this nature. This has come to our attention in the last 2 of 3 years.

It is my opinion that very careful consideration should be given to reestablishing this kind of program, which we know as an over-the-counter drug program for the nonservice connected patient.

The future needs for medical services is fast becoming a major concern of the aging veterans in Tennessee. This need can be met, in my opinion, by an expanded geriatrics research, education and clinical programs. The VA Medical Center in Murfreesboro seems to be a logical place for such an expansion due to the nature of the majority of the patients being treated there, the prime interest of the medical staff in geriatrics and the affiliation with the Meharry Medical School, which is emphasizing geriatrics, as I understand it, as a specialized field of medicine.

It has become evident from many things that have come to our attention. that some provision must be made for additional nursing care and facilities in our State. Even though there is a grant program available through the Federal Government in which the Veterans'

Administration can share in the cost of State-owned and operated nursing and domiciliary facilities, I personally believe that there is an urgent need for Congress to take the initiative in seeking new incentives for State governments and nationally chartered veterans organizations to work together in assuming equitable responsibilities for providing this care and these services, nursing home and domicilary, for the veterans in this particular state.

Mr. Chairman, the quality of medical and health care rendered by the VA in Tennessee is not the major concern of our veterans; rather, they are concerned about the quantity of such services that are and will continue to be available to eligible veterans. There are more than 225,000 of Tennessee's living veterans who are 60 years of age or older and the relatively low income of Tennessee families compounds the problem that we have in this area.

With regard to the entire staffs of the VA medical centers and the VA regional office, they have been most helpful in the work of a Select Committee of Veterans Affairs of the Tennessee House of Representatives in our General Assembly. They have worked with us, especially this past summer, with regard to problems related to agent orange. These VA personnel have met with the Select Committee, with people from the Tennessee Department of Veterans Affairs and with concerned veterans in an effort to share the latest scientific information and to guide affected veterans in their quest for answers to the problems that have been created by agent orange exposure. Insofar as I know, any Tennessee veteran who wished to be examined or receive information regarding agent orange has been served through these cooperative endeavors.

The Nashville regional office continues to be most outstanding, in my opinion. And one of the things that is outstanding I think is in the timely handling of claims for benefits by the Adjudication Division. The other divisions of that office seem to be keeping up with the demands made on them, with the possible exception of the Vocational Rehabilitation and Counseling Division where the number of pending cases was 130 in late January of 1982. This may be due to the need for additional counseling psychologists, but I suspect that it is more due to an increase in the number of applicants because of current economic conditions.

The VA regional office serves more than 1,500,000 persons; that is 542,000 veterans plus their dependents in Tennessee, and they do a fine job with it.

The major concern of veterans in Tennessee is that the VA regional office will continue to operate in Nashville and will not fall victim to some ill-conceived plan of regionalization such as that recently under discussions in some circles around Washington. Mr. Chairman, Tennessee veterans want the VARO to remain in Nashville.

Finally, Mr. Chairman, the one fact that underscores the validity of our concerns regarding future VA medical needs and administrative services in Tennessee is the 16-percent plus, almost 17 percent growth in Tennessee population shown by the 1980 census. More and more people are moving to Tennessee. Many Tennessee veterans within the last few months have lost their jobs and as a result, their medical insurance. These factors appear to be showing in the statistics regarding applicants and patients in the VA medical centers and clinics and the needs for certain services from the VA regional office in Nashville.

Mr. Chairman, this concludes my statement. I thank the subcommittee for its generous work in behalf of veterans and I will be happy to answer any questions you might have.

[The prepared statement of Mr. Roden appears on p. 55.]

Mr. MONTGOMERY. Thank you, Mr. Roden, I think we will move on down and hear the other testimony. I want to commend you, that was an excellent statement. You summarized and hit the key points and it was a well-prepared statement. Thank you very much.

Commander Whitten, we would like to hear from you. I know you had a tough time last week. It is nice to have you here. The organization is very strong and does an excellent job in Washington working for the veteran and for his or her dependents.

Commander Whitten.

STATEMENT OF B. H. WHITTEN, COMMANDER, DEPARTMENT OF TENNESSEE, DISABLED AMERICAN VETERANS

Mr. WHITTEN. Thank you, Mr. Chairman.

I will have to apologize for not having my prepared statement and getting copies to you. I have been out of town going over the State. We are preparing for our State Convention. We are, the Disabled American Veterans, and listed as the third largest veterans organization, but we will soon be number one.

I will say this, all veterans organizations help the veterans but that is what our prime goal is, to work with the veterans that have a service-connected disability.

Mr. MONTGOMERY. Mr. Whitten, let me state this for the record. If the veterans organizations in Tennessee and in my home state of Mississippi and Texas and Indiana are not active, we are not going to be able to protect these programs in Washington. Those organizations in other areas which are more active are going to get the funds and we are not going to be able to live up to obligations we have to these veterans. So we do not have any choice. If you do not have active veterans' organizations in the State of Tennessee and pull together, we just cannot make it in Washington. We have to have the grassroots support.

Mr. WHITTEN. That is true.

As I say, I apologize for not having in advance a written statement of this, but I had planned for someone else to be here because I was out of town, but they did not make it back and I got a call this morning at 6 o'clock from Washington that told me to be here.

But my major concern throughout the State of Tennessee, is not only in the State, it is everywhere there is a disabled veteran, where there is a veterans hospital, wherever it may be. I do not have any qualms against any of the administrators or the Regional Director here in Tennessee. We have a good working relationship with all of them. Since taking over the Department of Tennessee as the Commander, after our Commander passed away, I have been unable to attend the veterans hospital facilities like I want to, but I would like to assure them that as the Disabled American Veterans, not me as

Commander, but as the Disabled American Veterans, I will pursue and see that my people pursue that the disabled veterans get what they are supposed to get.

As Congressman Beard so stated, I think it was he, how can we expect to have people in our military service to fight for this country when they do not have nothing to come back to and be taken care of when they have given most of themselves for this country. We cannot go through and have a viable military service without something that they know, when I get back and I have given part of me for this, that I am going to be taken care of. That is our major problem today.

Yes; we have been here in Memphis at the VA Medical Center, Mr. Arnett is a very fine person, I can walk up to his office any day and he will talk to me. I have not been to the others, I have been to Murfreesboro, Mr. Pepiot was not there the last time I was there but we were welcomed cordially in the VA hospital in Nashville also.

But I have been myself, an outpatient at the VA center here and even though I had an appointment I would have to wait from 2 to 4 hours before I was ever seen by a doctor, sometimes I had to come back the next day. That is something—not me particularly, that is something that we are having problems with I am sure in other hospitals in other States, that even though they make appointments that does not mean they will see you at that time.

We do have problems like they were talking about, over-the-counter drugs. We have patients, disabled veterans that have been disabled, their legs have been blown off, a good friend of mine, his leg—he was in a tank and it was shot at and exploded and he has spasms in his legs. He cannot get the drugs that has been proven that work for him in the past when they have treated him, they have given him something else and it does not do any good. But that is what I find out in my travels throughout this State of Tennessee, that they welcome us but they do not give, I think and the veterans that I have talked to, the proper attention or the drugs that probably would help them go on through life.

And I have no other complaints with them other than maybe when a person goes for outpatient treatment or tests or medication, he does have to wait quite a bit of time, but other than that, I have gone out through the bushes and shook them and tried to get others to give me statements or something and I have been unable to get it.

And going back to the antiquated facilities. Yes; I would hate to get sick and go into say, the historical site and they say you cannot change this building but the guy cannot go there and get medical treatment. I have participated in other organizations and we have a lake, Mr. Chairman, in your State that is going to die because of the antiquities, as you may call it, refuse to let them do something. We cannot let the hospitals do this. We cannot let this country go down and our people that served this country and gave part of themselves not getting the treatment when they come back.

I cannot give you specifics. I could give it to you on my own case, but I have been unable to get any specifics due to my travels and we spent the week with your committee in Washington the other week too, Mr. Chairman.

Thank you very much.

[The prepared statement of Mr. Roden appears on p. 55.]

Mr. Montgomery. Thank you for a very fine statement and thank you for being here on such short notice.

We would like to now hear from Mr. Dan Jackson who is president of the Vietnam Veterans Association for the State of Tennessee.

STATEMENT OF DAN W. JACKSON, PRESIDENT, VIETNAM VETERANS ASSOCIATION

Mr. Jackson. Mr. Chairman, members of the subcommittee and Congressman Beard, I will run through this as quickly as possible and kind of hit the highlights.

I have heard complaints from approximately 2,000 veterans in the State of Tennessee, Virginia, North Carolina, and Kentucky. I have personally received rude treatment, the same as other veterans. I have also received treatment that was adequate.

One of the more popular instances of rude treatment starts when a veteran asks for an agent orange examination. It seems to bother VA personnel to perform this test or give any information on this test, especially what it consists of. No one in VA seems to know the appropriate test to give for agent orange. This means that you might get a blood test in one place or X-ray and then you might get a sperm count in another one. It varies. All they have to do is refer to Circular DM and S 10-78-83. If the veteran has a dishonorable discharge, the VA personnel should refer to Circular DUB 20-78-18. With information like this, why does VA consistently have problems giving the same test to everyone?

Many veterans have testified to this organization of long waiting periods of as long as 2 days. This is to have an agent orange test. I can see no reason for having to wait longer than 6 to 8 hours. Most veterans cannot take off from work to have an examination that takes this long, others cannot afford to. This type of problem can be heard all over the State of Tennessee, not in selected areas or veterans. Is this a way to discourage veterans from having this test?

The rude treatment usually starts with the receptionist or clerk in the waiting room. Like I said before, not all VA employees are rude. I have had a real good relationship with the administrators of two hospitals.

I have found that some doctors make judgments on veterans without any examination, others by looking at the veterans' records and talking to them. I do not believe that this is adequate.

Most veterans feel like the VA is trying to make them out as welfare cases and the VA is giving them a big favor by seeing them and treating them, much less treating them as a patient. This is an experience I went through both ways, good and bad.

Most veterans cannot buy insurance. You have very few patients of the Vietnam era if they had insurance. I grant you that. This is the reason most veterans go to the VA Hospital, simply because they cannot afford insurance or do not have insurance.

The communication gap between the veteran and the VA can and should be straightened out. We do not understand the VA processes that you have to go through for pay, meal tickets, and so forth.

These things are available to veterans in certain instances, yet we know nothing about them, the average veteran does not know anything about this. This information should be provided to the veteran.

The overall personality in the VA personnel should be improved. They show the veteran very little respect. Let us replace the personnel with negative attitudes with VA personnel that could be made up of the veterans.

I would like to say one thing in closing. In listing the hospitals as far as the treatment from good to bad; Murfreesboro is rated number one by this organization. They treat the veterans better than any that we have dealt with. Mountain Home is second. I have dealt with the administrator up there on several occasions and they have really went through for us. Nashville is rated third and Memphis is rated last.

Thank you.

[The prepared statement of Mr. Jackson appears on p. 57.]

Mr. MONTGOMERY. Thank you, Mr. Jackson.

We need these strong statements to know what the veteran is thinking. Thank you very much for the statement and we will get around to you with some questions about the information you brought to us.

Mr. Doten, representing the VFW, we are glad to hear from you and it is nice to see you again.

STATEMENT OF DAVID DOTEN, PAST COMMANDER, DEPARTMENT OF TENNESSEE, VETERANS OF FOREIGN WARS

Mr. DOTEN. Thank you, Mr. Chairman, members of the subcommittee. I am sorry that I do not have a prepared statement but I was not informed of the subcommittee meeting until 7:30 this morning when I got a call from Nashville about it.

The Veterans of Foreign Wars of the State of Tennessee know that we have four excellent hospitals in the State. Over the past 5 or 6 years I have had the opportunity of being in all four hospitals on numerous occasions and I have always found the staff and administrators, present ones and the ones before now, to be very cordial and receptive to the visits we have had.

We have had some problems with the VA Hospitals and because of it we have normally turned it over to our national organization and we have had inspections dealing with the problems that have come about.

The main problem that I hear from the veterans across the State of Tennessee during my travels now are the admissions to the hospitals. We have so many veterans who say they are not admitted to the hospital, they will go, they will wait 6 to 8 hours to be waited on, some of them will have to come back the next day, some of them have traveled 70 and 80 and 90 miles to go to the hospital. We feel that many of them should be admitted to the hospital but on the say-so of a doctor who we do not think has completely examined the patient, they have not been admitted.

I personally tried to get a person admitted 3 months ago in Memphis and called several people at the hospital. He is a disabled veteran and they said he could come back in a month or so and they would check him again, and his family was very upset that he might commit suicide, but the hospital said no, he could not come back now.

I had another acquaintance of mine 2 years ago that was denied admittance to the hospital here and had a heart attack in the parking lot a half hour later.

I believe that the admissions should be corrected and I blame this on some of the doctors at the hospitals, although I feel we have some of the finest doctors in any hospitals in the veterans hospitals in the State of Tennessee.

I have also heard some complaints recently about drugs not being given to the non-service-connected and to some of the service-connected veterans that did not receive the proper amount they needed.

Again, it is a privilege for me to be here and I appreciate to committee coming down to Memphis. Thank you very much.

Mr. **Montgomery**. Thank you very much for that excellent testimony, and thank you for being here today.

I will have one question and I might come back after the rest of the committee asks their questions.

Mr. Jackson, you say that veterans cannot buy insurance because of health problems. Do you care to expound or talk more about this area? That has kind of missed me, I did not know we had that problem, that it was a major problem with the Vietnam veteran.

Mr. **Jackson**. OK. A lot of us are showing health problems that we consider coming from agent orange. I approached an insurance company that sells for several companies, for insurance for the organization, health insurance. And our rate was going to be higher because we are Vietnam veterans.

Mr. **Montgomery**. What was that now?

Mr. **Jackson**. Our rate would be higher because we are Vietnam veterans. Personnally I cannot buy insurance on account of——

Mr. **Montgomery**. The health insurance was rated up because of——

Mr. **Jackson** [continuing]. It was rated up for the organization, yes.

Mr. **Montgomery** [continuing]. Well we will certainly look into this. Is it for individuals or for an organization of Vietnam veterans or——

Mr. **Jackson**. This is for our organization, it would be a higher rate as a group rate, it would be higher than the regular group rate of somebody that did not go to Vietnam.

Mr. **Montgomery** [continuing]. We will certainly look into that.

Mr. Hillis.

Mr. **Hillis**. Thank you, Mr. Chairman. I have a couple of questions.

Mr. Roden, you referred to the policy of dispensing over-the-counter drugs and as I recall the testimony of the panel that preceded you, they referred to them as aspirin, vitamins, and things of this kind. But I take it from what you said, it might include more serious things. Would insulin be included?

Mr. **Roden**. This is the type of thing that has come to my attention, Mr. Hillis. I talked with a veteran that was diabetic and he had received the medicine, according to his statement, for about 10 years and then it was cut off. Now this was a couple of years ago when this took place. I have talked to some others who had certain cancerous conditions that have had medicine, glaucoma, and some of them had certain heart disease, that has been the term that has been used, with regard to that. Not aspirin or things of this nature, according to the testimony, but specific drugs that were provided under a former policy and then this was changed, I think it was about 2 or 3 years ago when the changes were made. These are people that, as I understand it, the drug was necessary to stabilize their condition and keep them that way. They were not under the care of a physician at the VA hospital in the sense that they would go back every so often, but as long as they had the medication they were doing OK. And this was cut off and many of these people are not able to obtain the drugs or get them any other way.

Mr. HILLIS. Thank you. I was not personally aware of this and certainly as a committee I think this is something that we ought to look at very closely.

Mr. Jackson, I would like to ask your comments about the separate facilities that have been provided off of VA hospital campuses, so to speak, for counseling of Vietnam veterans. Has that been adequate in this area? Do you feel like it is an effective program? What are your comments about it?

Mr. JACKSON. I have a discrepancy here as far as a meeting we had in Union City, Tenn., which is north of here. We were supposed to have a speaker from the Outreach program and I do not understand if he had called and said he was not coming up there or not, but other than that, I use them at a lot of our meetings in different parts of Tennessee and we have worked with the Outreach program and have a good working relationship with them and I think they are doing an excellent job.

Mr. HILLIS. Good. As I understand your testimony, if a Vietnam veteran comes in the hospital, that agent orange is kind of a flag that produces problems in how welcome you are or the type of reception you receive?

Mr. JACKSON. This is a problem I can see, as far as myself is concerned, when I had my first agent orange test, which consisted of a blood test and X-rays and urinalysis. This has been proven not to be accurate. As a matter of fact, the one they recommend is not accurate either, but it is better than not having any.

Mr. HILLIS. Thank you. That is all the questions I have.

Mr MONTGOMERY. Thank you. Mr. Hall.

Mr. HALL. You say the test is not accurate that they give you. How have you made the determination that that test is not accurate?

Mr. JACKSON. I have talked with several research technicians and they recommend that a deep fat biopsy and a liver biopsy is probably the only way it will show up if you have contamination.

Mr. HALL. I want the name of the insurance company that has refused to give you insurance because you are a Vietnam veteran.

Mr. JACKSON. They will not refuse to give it to us, it is at a higher rate.

Mr. HALL. Give me the name.

Mr. JACKSON. I do not have it with me. I can obtain this by telephone or either send it in the mail.

Mr. Hall. Have you been denied insurance because you were a Vietnam veteran or have they rated you because you were a Vietnam veteran?

Mr. Jackson. $200 a month.

Mr. Hall. Have you personally been denied or been rated because you were a Vietnam veteran?

Mr. Jackson. Yes, sir, I have. It was rated too high for me to think about buying it.

Mr. Hall. But was it done because you are a Vietnam veteran?

Mr. Jackson. I could not think of anything else because I have had heart problems, I have got this rash on my body, I have a nervous condition and these are the statements that were put on the——

Mr. Hall. Now is that because you as an individual have these problems or because you were a member of a class who happened to be Vietnam veterans?

Mr. Jackson. This was on an individual basis. What I was talking about awhile ago was where I tried to get group insurance about 8 months ago for our organization. The rates would be higher for us than it would be for people our age that did not go to Vietnam.

Mr. Hall. Well, do you know of any insurance company that has rated an individual higher rates just because, solely because he or she was a veteran of the Vietnam war?

Mr. Jackson. The approach I used with insurance companies was that we were Vietnam veterans, I would like to know what our rates would be, would it be different because we are from Vietnam. And he said that this insurance company did not care to insure us, that they would insure us but it would cost more than somebody that did not go to Vietnam in the same age group.

Mr. Hall. Well did you ever inquire to see the name of that insurance company?

Mr. Jackson. I can obtain this address for you, yes.

Mr. Hall. Would you do that?

Mr. Jackson. Yes, sir, I will.

Mr. Hall. Give it to this lady that is recording and she can make it part of this record.

Mr. Jackson. OK.

Mr. Hall. And you will do that?

Mr. Jackson. Yes, sir.

[Mr. Jackson supplied the following information:]

Vietnam Veterans' Association, Inc.,
Rogersville, Tenn., March 23, 1982.

Subcommittee on Oversight and Investigation,
Cannon House Office Building,
Washington, D.C.:

I contacted the person that I told the Committee about that wanted higher rates for insurance pertaining to veterans of this organization. When I ask him to give me the figures on paper he told me that he could not do this. He had read the paper this morning. He is afraid of losing his job probably. I will still try to obtain this information for the Committee soon as possible. I apologize to the Committee for their inconvenience pertaining to this problem.

Sincerely,

Dan W. Jackson, *President.*

Mr. Hall. All right.

Mr. Whitten, we have heard testimony here today from Mr. Jackson and Mr. Doten talking about problems that they have seen, they are familiar with. And if I understood your testimony, you stated that you cannot find any real complaints of any kind that these two gentlemen have found to be very obvious in their organization. How do you account for that?

Mr. **Whitten.** I feel like it is probably the people that they talk to, although they said they did have contact with some disabled veterans. But as far as me personally, I have been unable to get anybody to give a statement other than—as far as mistreatment or not getting treated, that it is delayed quite a bit. Sometimes it may be 2 hours, 4 hours, sometimes it is the next day they tell them to come back.

Mr. **Hall.** Have you been told by any members of the DAV that they have been denied insurance because they were from the Vietnam War?

Mr. **Whitten.** No, I have not.

Mr. **Hall.** Thank you.

Mr. **Montgomery.** Mr. Beard?

Mr. **Beard.** Would you like to——

Mr. **Lollar.** If I may, just for a second.

Mr. **Montgomery.** You might identify yourself.

STATEMENT OF RON LOLLAR, COUNTY SERVICE OFFICER, SHELBY COUNTY

Mr. **Lollar.** I am Ron Lollar, I am the county service officer for Shelby County.

Our office carries power of attorney with the American Legion, VFW, World War I Barracks and Order of Purple Heart, Marine Vietnam veterans. Now personally I can say that I have never been asked the question if I was a Vietnam veteran when I was applying for insurance so I cannot address myself to that particular point.

I would like to address myself, and I do not have a prepared statement, but I would like to say something if you gentlemen will bear with me shortly. We have heard a lot and there have been studies on the POW's, POW's from all wars and their treatment at our local VA center. When we file a claim, gentlemen, and this does relate to the hospitals, when we file a claim for a service-connected POW, they may have been released from the service with 15 to 16 different types of diseases, bone diseases and everything else while they were prisoners of war—I can document these—they come home, they were discharged rather rapidly and you gentlemen would probably know better than I would, and they got back out in the world. They wanted to get to work, they were patriotic people and now they go in for an examination for nervous conditions or bone diseases or diabetes or whatever we are talking about and those VA doctors have said this may not be as a result of your treatment as a POW.

Gentlemen, I contend civilian doctors will tell you real quick it is very possible that a lot of these diseases incurred as POW's could later on trigger other types of diseases. Now why can not our VA doctors either research it more thoroughly or let us know something about these POW's that are having problems. These problems are quite real.

Or the veteran goes to the VA hospital, in one instance, and a man is 40 percent service-connected, he spent 27 months in Stalag 17, he is discharged with several different diseases and all he gets is 40 percent on nerves and POW is not even in his record book.

Gentlemen, these are human errors that I contend that the administrators of these hospitals can only—tell them the limits, you know, these men, we do work well with them, it is not their fault that these things happen. The human factor, the human concern factor of the individuals working at these facilities is in question.

Mr. MONTGOMERY. We thank you for bringing up that point. Now Congress has just passed H.R. 1100, which we think in most cases will correct the situation that you pointed out. If there is any doubt, the administrators now have the authority to make these disabilities or problems that the veterans who are ex-prisoners of war are having, and they can be declared service-connected. And we have about 100,000 of these veterans in the country now, ex-prisoners of war, and they live a shorter time and they have more mental and medical problems than those of us that were not captured.

But we should give H.R. 1100 a chance, it has just been implemented. We think it will correct a lot of the problems that you have mentioned here this morning and help the ex-prisoner of war.

Mr. LOLLAR. Mr. Chairman, may I go on very briefly? I know I was not slated to speak, but I would like to go on and say this.

We have 105,000 plus veterans, eligible veterans in Shelby County, one-fifth of the State's veteran populus is in the county we serve. I mentioned earlier the POW. I think on service-connected claims, and this has been gotten to, when you have a veteran going in for a service-connected claim and he has had a traumatic leg amputation; which is when a bullet physically removes that leg from that person's body; in World War II, and he goes in and has to sit 8 hours at the hospital and he has a job he is trying to get back to make a living. Sure, you are going to wait in any doctor's office, and this is the thing we hear, you are going to have to wait anywhere you go. But I think 8 hours 1 day and then being called back first the next day when you have got an appointment for that morning at 9 o'clock is a little unreasonable. And there again, this is not the only instance.

Gentlemen, I would not be so naive as to come before you and not be able to document some of my cases and history of 6 years in this office in this county. Like I said, I am not in any way saying anything against our administrator at the hospital, because in many instances; we have contacted him and he, without a doubt, in most instances we get great response. But this is not on the administrator's level. The administrator can go to a professional and a doctor will only in some ways—and they will sometimes, God forgive me, in an arrogant attitude tell a man he does not know what he is talking about and he might be close to death.

So it is not the administrator, the doctors need to be questioned by somebody. And that is all I have got to say other than on the pensions. Two years ago in Washington, D.C., at a Service Officers' Conference, we were approached by a member of the Veterans' Administration, the head man for the compensation and pension section, and he told us that pension was no better than welfare. He stood there and made the statement to us, that non-service-pension was no better than the welfare system, when history, title 38 and everything bears out that it is a benefit earned by the veteran. And when part of the trouble is within the system itself, when the head of the system tells you that it is no better than welfare, then I think that system needs to be evaluated at a far higher range than on a local level.

Gentlemen, thank you for your time.

Mr. MONTGOMERY. Thank you very much.

Mr. Beard.

Mr. BEARD. Thank you, Mr. Chairman. We appreciate those comments.

Let me ask Mr. Jackson, one point that I was somewhat interested in is the fact that you stated the tests varied for agent orange from one facility to the other. Is there a—maybe counsel or the chairman can respond as to is there a standard test established? And yet you have individuals that you could show their particular type test that they received at these various hospitals because I think definitely that is something we can reemphasize.

Mr. JACKSON. It definitely varies from one hospital to the other and in one or two cases it has varied in the same hospital. It also varies if you call in and make an appointment or walk in, this also varies.

Mr. MONTGOMERY. Mr. Roden, did you want to comment on that?

Mr. RODEN. Not in itself, Mr. Chairman. The legislative committee to which I referred to the Tennessee House of Representatives had hearings this year and we had several of the physicians, every hospital was represented other than Memphis, we did not come any further west than Nashville, and I think that a lot of the divergence that exsited initially in this may have been taken care of, Congressman Beard, and it may be that people who have communicated with Mr. Jackson may have been in those early stages.

Now I am not aware of a significant difference in this respect based upon the testimony of the physicians that we had before the committee, but I do know there is a divergence of opinion with regard to what should constitute one, but so far as I know there is pretty well a standard procedure now for this in the hospitals.

Mr. BEARD. I would just like to—has it been discussed in committee before as to the different type tests, the different attitudes toward which type of test is a meaningful test? It was mentioned by Mr. Jackson that some researchers have stated that a liver biopsy was one of the only ways to legitimately find that. I just wondered how far we have gone on that.

Mr. MONTGOMERY. Staff informs me that this test is coming from different research divisions and university medical centers around the country. Mr. Beard, the whole agent orange problem is really in the factfinding area. It is tough to do. I wish we could come up with concrete information that agent orange has caused these problems with veterans and affected children. We just cannot get the information. It is just slow in coming and these tests have come to us in various ways and I am sure Mr. Jackson is right, we probably have not done a good job, I am not saying in Tennessee, but in other areas of examining these veterans to determine the effects of agent orange, but quite frankly, we do not know what we are looking for. And it just takes years of research to come up with some type of concrete information of what damage agent orange may have done to these veterans.

Mr. Hillis.

Mr. **Hillis.** If I might comment on this general area, I have been a member of the committee for almost 12 years and I have seen a tremendous change in the attitude, I think, toward agent orange. When I first went on the committee, the attitude that came to us from the VA was one of it is not a problem, that the charges are being made that it causes problems are not accurate. It was kind of a tempest in a teapot.

I think today, though, that is not true at all, and this committee has always taken a broad view and pushed and insisted that further research be done. That is going on now, and there has been a complete turn to the point of view that there is foundation for the worry that you express here. The research is going on, I hope we are going to find the answer and do something about it.

Mr. **Beard.** I have no other questions, I would just like to say, Mr. Doten referred to it, Mr. Jackson, the Service Officer, right down across the line, and I guess when I have my courthouse sessions and meet with my veterans, the one thing that I hear the most, and I want to reemphasize what has been said across the broad, is the—understanding the numbers involved make it quite difficult, but there must be a problem when there is this much smoke as to people who say that they have an appointment, they went, they sit for 6 to 8 hours and then were told to come back the next day. These are people that do work on an hourly basis and you take a day out of their income and it is tough. And there are, I am sure in some situations, some certain coolness that develops and I think that emphasis needs to be made to the employees of these different institutions that they need to be extremely—re-emphasize the need to be sensitive, of being polite, of being courteous, of being sensitive to the needs of these different veterans, knowing there are always going to be some veterans or some individuals that are trying to cop out of the system or trying to abuse the system, but that is the exception rather than the rule.

Mr. **Montgomery.** I totally agree with you, and the problem is these people who work in the Regional Offices. Mr. Bielak can probably expand on that more, I guess they do lose patience, but you know, that is their job and they have got to have patience and work with these veterans.

For the information of our friends here in the Memphis area, this administration did not cut back on medical care in fiscal year 1983. We will have an additional 1,300 employees in medical care for the whole medical system in the Veterans' Administration, when most areas are being cut back. Of course we realize we have Korean veterans and World War II veterans who will need acute care and we have got to do something about it.

So, there has not been a cutback in medical care for fiscal 1983, and I think we were fortunate in that.

Just to kind of wrap it up with these veterans organizations, we think we are going to be able to protect the areas where this administration recommended cutbacks, in service-connected areas—compensation for service-connected disabilities and the vocational education areas, we will protect them. We will have to take our cuts, but as far as protecting hospital care, medical care for the veterans and compensation and pensions, we think we will come out pretty good in fiscal 1983. Compared to other departments of Government, we came out fairly well in the veterans programs last year. We had to take our licks in burial benefits, we had to take our licks in correspondence courses, educational courses, but so far it is not all bad in Congress.

We appreciate very much you gentlemen being here. We have one more panelist that we would like to bring up at this time and we appreciate his patience.

Thank you, you helped us very much.

Mr. MONTGOMERY. Mr. Bielak, who is the Director of the VA regional office in Nashville, Tenn. Thank you for being here. We had to shift you around from being No. 2 to last, but I have about decided now that in these hearings, we should probably have the veterans' organizations and others testify first and then have our Federal Government directors testify at the end and answer some of these complaints and comments. You heard some of them and they affect your organization.

Mr. Bielak.

STATEMENT OF ROBERT S. BIELAK, DIRECTOR, VETERANS ADMINISTRATOR REGIONAL OFFICER, NASHVILLE, TENN.; ACCOMPANIED BY PATRICK K. COURTNEY, ADJUDICATION OFFICER, VETERANS' ADMINISTRATION REGIONAL OFFICE, NASHVILLE, TENN.

Mr. BIELAK. Thank you, Mr. Chairman. I have submitted a formal prepared statement to the committee and I would like to have——

Mr. MONTGOMERY. Without objection, the full statement will be put in the record.

[The prepared statement of Mr. Bielak appears on p. 59.]

Mr. BIELAK. I would like to present a brief summary of that statement.

Mr. MONTGOMERY. Would you like to introduce the gentleman with you there?

Mr. BIELAK. Yes; I would. This is Pat Courtney, the adjudication officer in our regional office. I brought him along to help me answer any questions that you may pose. His activity is responsible for the processing of education, compensation, and pension claims.

I would like to welcome you and the subcommittee members, Congresman Beard and members of your staffs to Memphis, Tenn. I would like to express on behalf of the 250 employees of the VA regional office their appreciation for your willingness to bring your subcommittee to our area to receive testimony on veterans' programs and problems. As I mentioned before, I have Mr. Courtney with me and he is our adjudication officer, and he will be on hand to assist me in providing answers to any questions that may arise.

Mr. Chairman, with your permission, I would like to first give you a brief overview of our operations. The Veterans' Administration regional office at Nashville, Tenn., is one of 58 regional offices in the Department of Veterans' Benefits. The Nashville regional office has jurisdiction of veterans benefit programs throughout the State of Tennessee. Benefit programs include: Compensation, pension, education benefits, home loan guarantees and vocational rehabilitation programs.

With about 250 employees located at Nashville, we strive to provide quality service to the 541,000 living veterans in the State of Tennessee. There are approximately 167,000 Vietnam-era veterans in Tennessee. We like to think that we have been successful in this endeavor in that from time to time operating elements in our office have been recognized for their excellent performance under the Department of Veterans Benefits evaluation system. For instance, just last fall our Adjudication Division was presented a commendation for high level achievement approved by Chief Benefits Director Dorothy Starbuck. Historically, the Nashville regional office's overall claim processing timeliness is better than the national and regional averages meaning that we are just a little bit faster in processing claims. This has been an historical pattern. So I am not going to take any credit for that.

In terms of workload and beneficiaries, the Nashville regional office ranks 22d in size and processes about 2 percent of the national workload.

The seven operating divisions: The Adjudication Division processes applications, develops evidence and makes decisions on claims for various benefits, including educational assistance allowance and educational loans. The adjudication division also authorizes the payment of awards and makes appropriate input now through the Target system, to compensation, pension, and education ADP systems.

We have an Administrative Division that provides support service to regional office elements as required.

The Finance Division administers a comprehensive and detailed accounting system for regional office operations including payments to certain veterans and beneficiaries. The finance division also conducts a program of payment of administrative expenditure incident to operations and administers certain collection activities for the regional office.

The Personnel Division provides service in all phases of personnel administration.

The Loan Guaranty Division processes applications, develops evidence and makes determination relating to entitlement to home loan guaranty benefits. The loan guaranty division also makes appraisals to establish reasonable values, services loans, acquires and disposes of properties and assists certain physically handicapped veteran who purchase a home with he aid of a grant.

The Veterans Services Division provides information and assistance to beneficiaries on veterans benefits programs. Veterans Services Division is usually involved where contact is made with the public including operation of a statewide toll-free telephone network. You can reach the Nashville regional office from anywhere in the State at the price of a local call. The Veterans Services Division is also a liaison with educational institutions and education compliance survey program and conducts field exams and supervises payments to beneficiaries under legal disabilities. We also provide public contact service at each of the VA medical centers and clinics here in the State of Tennessee.

Vocational Rehabilitation provides a full range of counseling, vocational rehabilitation training and vocational adjustment services to disabled veterans and other eligible persons.

I would just briefly like to comment on the Target system. Target is an automated compensation, pension, and education benefits delivery system. The Target system was activated at the Nashville regional office in February 1979. At this time, both the inquiry part of the system and claims processing portions of the system are in operation. During the first week of February 1982, the Nashville regional office processed 25,598 transactions over the Target system. Our employees, the users of the system, are enthusiastic about it and we are confident that as we gain experience and the problems in the system are ironed out, it should continue to improve job performance and provide more timely service to VA beneficiaries.

In our regional office we also provide space and office facilities for a number of national and veterans service organizations as well as the Tennessee Department of Veterans Affairs. These offices and their staffs, under powers of attorney, provide advice and assistance to veterans and other beneficiaries in presenting their claims to the agency. They provide a needed service to their members and nonmembers alike. I might also add, they also provide to me and my staff the type of constructive suggestions for improvements in our operations which serve to improve overall service to our clients. Those organizations that have space in our office are: The American Red Cross, AMVETS, Disabled American Veterans, the Tennessee Department of Veterans Affairs which represents the American Legion, Fleet Reserve Association, Military Order of the Purple Heart, Veterans of Foreign Wars, and Veterans of World War I of the United States.

Mr. Chairman, this concludes my statement and I will be glad to try to answer any questions you might have.

Mr. Montgomery. Thank you very much. You do very well testifying before Members of Congress. You wrapped that up very quickly. Thank you.

Mr. Roden made a point that I then mentioned. It was proposed this last fiscal year that the regional offices be closed around the country and be moved to Washington like they have done in the social security system. For the record, this committee and the Senate Veterans' Affairs Committee were able to authorize funding so this would not happen. It just does not make sense to move all the regional offices from Tennessee, Nashville, and Jackson, Dallas, and Indianapolis to Washington.

Do you have any comments on the centralization of regional offices?

Mr. Bielak. Well I guess I kind of agree with you. I do believe that—well first, I am for a balanced budget and I think most of us are. I do believe that perhaps centralization of some activities could achieve savings. I cannot as a manager, a responsible manager, refute that statement.

On the other hand, what is lost in this process? The ability to, I think the ability for us public officials to serve our clientele, especially the veterans. The fact that we are near them improves not only our ability to serve them but makes us more responsive to their needs. And I, while I think that maybe some overhead savings could be achieved by regionalization, I think it would be at a considerable loss in terms of service to our clients.

Mr. MONTGOMERY. Well I certainly agree with you. And I think I am safe to sit here today and say that I see no centralization of these regional offices in the very near future.

Mr. Hillis.

Mr. HILLIS. Thank you, Mr. Chairman. Mr. Bielak, I noticed your testimony about the Target system. I sat as a member of this committee sometime ago when we got into hearings about that system and there were problems with it. It had not been fully instituted yet. Do you find it working satisfactorily to meet the needs of your region and the regional office?

Mr. BIELAK. I find it very effectively meeting the needs of our regional office. First, I think that our people were—even when we first implemented the system and had considerably more problems than we have now—I think they were very enthusiastic about it, liked using the system. It does enhance or speed up our ability to serve claimants and answer inquiries. I think you are familiar with that.

I think that the agency is making considerable progress in ironing out those problems that existed earlier. I asked Pat to put together a report on what our current experience is and during the last 2½ months, we have experienced less than 4 hours of downtime over the total system.

Mr. HILLIS. Could you put that report if it is available into the record of this hearing? I think that would help us.

Mr. BIELAK. I might have to make a little change, there are some notes on there. But yes, let me answer it that way.

[The following was subsequently submitted for the record:]

System down-time has not been a major problem for some time. In the last 2½ months, Data Processing Center, Hines, has been unavailable for a total of 4 hours and 57 minutes, with actual down-time occurring on 11 days for time periods ranging from 5 minutes to one hour and 24 minutes. On only one occasion has our local system been unavailable since January 4, 1982, when a level 3 power supply blew out, inactivating the system for one hour and 5 minutes. Honeywell field engineers provide timely, cooperative assistance.

Mr. HILLIS. Thank you very much. That is pretty good follow up. I did go to our Indianapolis office to view it and while it was working, it was truly miraculous. It did have periods of downtime and they would have to go back to the former system and it was very disruptive. But I understand from your testimony and what I hear generally is that those long periods of downtime seems to be behind us.

Mr. COURTNEY. Yes, sir, I would certainly agree with that. The system has provided unique edits in the award process that alert the processor when perhaps an error was made in an entry, and that also has aided us considerably in being able to process timely, effective, and efficient awards. It is an excellent system. I think one of the drawbacks that we continue to experience, but see improvements on a monthly basis, is in the letter writing package, and capacity that the system has in terms of overall development of claims and in producing award letters. There are consistent improvements over time in that package, however, and the system is generating a larger volume of letters so that they do not have to be prepared by regional office employees.

Mr. **Montgomery**. Thank you. Before I yield to Mr. Hall, what is the average time of processing a claim on compensation or a pension? Do you keep a record on that?

Mr. **Courtney**. In the Nashville regional office for the last 12 months, we have averaged 111 days on compensation claims. That compares to the national average of 125 days. We do experience some difficulty in obtaining service medical records and documentation of service from notably the National Personnel Records Center. I think one of the difficulties there is in the manner in which records are forwarded from the separation point to the holding facility. There are occasions when we experience 6-month lapses of time in individual claims.

Mr. **Montgomery**. What about pensions?

Mr. **Courtney**. Pension claims are processed on the average of about 70 days.

Mr. **Montgomery**. Oh, you do that much quicker.

Mr. **Courtney**. Yes, sir.

Mr. **Montgomery**. Have you ever made a comparison with social security claims and the compensation and pension claims in the State of Tennessee?

Mr. **Courtney**. No, sir, I have not.

Mr. **Montgomery**. Mr. Hall?

Mr. **Hall**. Mr. Bielak, did you testify in the hearings we had in Nashville a year or so ago?

Mr. **Bielak**. Yes, sir.

Mr. **Hall**. I thought you did. At that time we were having some discussion about the veterans loans and how to collect the deficiencies missing out of the program. I think at that time there were some questions that arose about the Veterans' Administration having a procedure where they would write a letter to the veteran who had defaulted and usually it got not too great a response. We suggested at that time that it might be a possibility to work with the U.S. attorneys and refer these cases—I do not know whether this gentleman was there at that meeting, I believe he was.

Mr. **Courtney**. Yes.

Mr. **Hall**. Refer these cases to the U.S. attorney's office after a series of letters did not get the desired results and that was discussed at that time. Has that process been implemented in this area or not?

Mr. **Bielak**. Well it has been, kind of a variation of it. There have been some changes that were either regulatory or legislative that now allows the VA District Counsel to pursue debt collection in debts of under $1,200. Over $1,200 we are still referring those debts to the U.S. attorney for collection.

Mr. **Hall**. So anything under $1,200 you are handling through the house counsel for the VA?

Mr. **Bielak**. The house counsel for the VA.

Mr. **Hall**. If it is $1,200 or over, you are referring it to the Department of Justice?

Mr. **Bielak**. Yes, sir.

Mr. **Hall**. Do you find that that is having the desired result on collections, when those are referred to the Department of Justice?

Mr. **Bielak**. Well we have been in this program of using our attorneys for about 6 months. From what I can tell in talking to my local counsel, is just that initial letter going out over the legal entity of the organization, the district counsel, is getting people's attention and they are being much more responsive to that letter than they were to the earlier letters that were going out from our fiscal activity, be it the regional office or the centralized accounts receivable activity up at St. Paul.

Mr. **Hall**. But anything over $1,200 you are still referring to the U.S. attorney's office.

Mr. **Bielak**. That is correct, sir.

Mr. **Hall**. Well have you had any input as to whether or not those letters that are going out from the U.S. attorney office over $1,200 have had good results?

Mr. **Bielak**. I guess I am just not familiar enough with that situation that I can answer that question. If I had to judge the reaction that we are getting by using our counsel, there would have to be a better response than what we have had in the regional office.

Mr. **Hall**. Do you have any thoughts on that?

Mr. **Courtney**. I do not have any specific information as to facts and figures. I am aware that that program has been in effect longer than our own local collection actions and it has generally been very effective.

Mr. **Hall**. What is your deficiency rate now on your loan guaranty program? On page 4 you state that in fiscal 1981 you guaranteed 2,300 home loans for $102 million. What is the deficiency rate on those loans?

Mr. **Bielak**. It would seem to me that the average loan in default rate used to run 3 and 4 percent. Currently it is closer to 5 and 6 percent.

Mr. **Hall**. Has that gotten that way during the last 12 months?

Mr. **Bielak**. Last 12 months, yes, sir.

Mr. **Hall**. All right. Now you heard today——

Mr. **Beard**. Will the gentleman yield on that?

Mr. **Hall**. Yes.

Mr. **Beard**. I was just curious about that line of questioning. Did you notice any increase as a result of the 1978 bankruptcy law, the new bankruptcy law, where bankruptcies increased dramatically, I think by 100 or 200 percent? I wondered if that has had any effect.

Mr. **Bielak**. The only effect that I would report—and this is merely based on comments from our loan guaranty people and people in the district counsel's office, is that we are seeing those cases that finally end up as defaults, go to a claim being paid and the veteran ends up with a debt owing to the government, as are other indebtednesses, do turn up in the bankruptcy courts.

Mr. **Hall**. Do you have any percentage of increase of bankruptcy cases in the last 12 to 18 months?

Mr. **Bielak**. I am sorry, Congressman, I just cannot answer that.

Mr. **Hall**. Can you get that information?

Mr. **Bielak**. Yes, sir.

Mr. **Hall**. Would you make it available to us?

Mr. BIELAK. Yes, sir.

[The following was subsequently supplied for the record.]

I regret to report that we have no meaningful specific data available at this regional office that would reflect the trend in disposition of indebtedness cases by discharge through bankruptcy. As reported at the hearing, it is our observation that there has been an increase in the number of foreclosures and indebtedness cases involved in bankruptcy proceedings.

Mr. HALL. Now you have heard some people testify here today, Mr. Jackson and some of the others, with reference to some of the problems that they are having with the veterans' hospitals. I assume you were here when that testimony went on.

Mr. BIELAK. Yes, sir.

Mr. HALL. Are you familiar or have you heard of any of those problems arising from these various organizations in the VA hospitals?

Mr. BIELAK. Well I have participated in or attended many of the hearings conducted by the Special Select Committee of the Tennessee Legislature on Agent Orange. At some of those meetings we did hear some of the things expressed by Dan Jackson. However, when you think in terms of the number of people that appeared at those meetings and relate the numbers to the total population, I do not know whether they are meaningful or not.

For instance—of course, I guess Congressman Beard conducts local courthouse meetings and has had some experience with this too—we had an announced meeting up at Nashville on an evening, advanced publicity to that meeting I thought was pretty good, conducted by the local Tennessee Legislative Committee. It was held at a well-known American Legion Post there, easy enough to find and it was a reasonably nice evening. There were not more than 15 actual veterans who came to complain at that meeting about agent orange and other matters.

Some of those same veterans were from Dan Jackson's group who had appeared at another meeting up in upper east Tennessee, I do not remember exactly where. At a followup session the next morning, we only had one or two additional new veterans and that meeting was also publicized. So I am wondering—yes, while some of these complaints may be valid and I am sure the person affected is well aware of what happened to him, but I am also wondering in terms of total overall service provided and the number of beneficiaries that we are treating, I do not see any ground swell.

Mr. HALL. Is it your testimony that all of the veterans hospitals are administering the same agent orange test to all veterans who claim that they may have had some reaction from agent orange?

Mr. BIELAK. Well I would guess from some of the comments that the test is different but——

Mr. HALL. Not guess. Do you know?

Mr. BIELAK. No, I do not know that.

Mr. HALL. Should you not know that?

Mr. BIELAK. Seeing as how I do not really have any jurisdiction over medical facilities.

Mr. HALL. I am sorry, but should that not be within the purview of your organization to know whether or not standardized tests are being given for agent orange?

Mr. **Bielak.** Let me back up. I do know that there is a standard instruction put out by the Department of Medicine and Surgery to cover the agent orange examinations. With that in mind, with those instructions each agent orange examination could take on a different track as a veteran is examined and his individual complaints are diagnosed and the findings of the various tests as they are being taken.

Mr. **Hall.** I understand that.

Mr. **Bielak.** So each one of them could end up significantly different I think although they are starting out with the same set of instructions.

Mr. **Hall.** Well, are all of the hospitals starting out with the same set of instructions, as far as you know?

Mr. **Bielak.** Oh, yes, sir; yes, sir. I guess I did not—comprehend the initial question. My apologies.

Mr. **Hall.** Thank you.

Mr. **Montgomery.** Mr. Beard.

Mr. **Beard.** Thank you. Gentlemen, I will be brief, I know that committee and staff have an airplane to catch to go back to Washington, we are in session.

I would just out of curiosity, somewhat as a sidelight, was the Department of Veterans' Affairs, were they participants in the flexitime experiment?

Mr. **Bielak.** Yes, our station experimented with flextime.

Mr. **Beard.** Just out of curiosity, did you experience some of the problems as to the fact that needed personnel during the work day not being there, or what was your overall opinion of flextime?

Mr. **Bielak.** Two things that were significant. We did stay on the flextime system for approximately 1 year. In terms of performance indicators we use the words productivity and effectiveness, we did notice a decline in the performance indicators for our regional office.

Second, most of my supervisors and division chiefs were unhappy with the system because when you wanted somebody they were not there available. If you wanted to schedule a meeting, you had to be sure when everybody was going to be there so I can schedule this meeting, and that type of thing. Frankly, it just did not work for the Nashville regional office.

Mr. **Beard.** One other question. The people out in the field, I know the different bureaucracies express a great deal of frustration at some of the rules, some of the requirements that are passed on from Washington, from the ivory towers of Washington, D.C., from those people who in many cases have been out of the field for a long, long time; decisions that in some cases lead to more and more paperwork, duplication, et cetera. And understanding too that this might place you on the spot just a little bit because in some situations you respond to these people, but are there a couple of rules or regulations right now that just hit you square in the face as to when it was issued to you, came down through the chain of command, you said this is absolutely the most absurd situation I have ever seen, duplication, I mean it is going to waste my time and we could be much more productive than that. Are there a couple of situations like that where it is difficult for you to have the opportunity to tell the committee, look that does not help us do our job?

Mr. **Bielak**. Well I guess I really had not considered that question being posed here. I just tried to recall in my mind about this happening recently, and frankly, it has not. I do not remember it occurring in the very recent past. I remember doing that at some time or other in the past, but I do not remember exactly what the rule was or what I was talking about.

Mr. **Beard**. At this hearing if we asked you to walk away from here and you go back to your office and you sit down with your administrators, your supervisors and say let us name three things right now that we are required to do by the people in Washington that do nothing to help better the veterans situation, does nothing to help our efficiency or productivity, it is an absolute waste of time and duplicity involved, do you think you could probably come up with two-or three things?

Mr. **Bielak**. I suspect we could.

Mr. **Beard**. I think it would be interesting to submit us about three of what you consider the most time consuming, inefficient type things.

Mr. **Hall**. Will the gentleman yield?

Mr. **Beard**. Yes.

Mr. **Hall**. The first one may be answering a lot of questions from Congressmen in Washington. [Laughter.]

[The following was submitted for the record:]

Note.—We were only able to identify two items for submission. These are field station viewpoints, and reasons for continuing requirements may not be readily discernible from there.

1. The quarterly report of status of education loans—"VA Education Loan Payment/Default Report (RCS 22-8)" requires that this report be submitted broken down by training establishment (facility code order). From a field station viewpoint, compilation and reporting of this information in that format is extremely time consuming and it is questionable if the data submitted serves any useful purpose.

2. It may well be time to reevaluate assistance offered educational disadvantaged veterans through United States Veterans Assistance Centers (USVTC) at regional offices. With the diminishing number of separating veterans eligible for education benefits under Chapter 34, and the small number who entered service after January 1, 1977 and participated in Veterans Education Assistance Program (VAEP), the elaborate contact and diary system maintained on these recently separated veterans may have outlived its usefulness and effectiveness. Further, all recently separated veterans are provided a packet with veterans benefit information through the Veterans Administration Discharge System (VADS). In addition, most contacts with recently separated veterans indicate that they have already applied for VA benefits or have already made inquiry on veterans benefit programs, thus rendering our contact efforts unproductive.

Mr. **Beard**. That is all I have. I think I will just close right here so we can get Congressman Hall back on the airplane and out of here.

Let me just once again thank all members of the staff and committee for coming down here and giving us the opportunity to participate and once again I commend the chairman for the outstanding job that he has done on behalf of veterans and I do sincerely appreciate you coming to my home district.

Mr. **Montgomery**. Thank you, Mr. Beard. Mr. Bielak and Mr. Courtney, we appreciate your testimony here this morning.

Congressman Beard, on behalf of the subcommittee members who have come here to Memphis, Tenn., I think it has been an excellent hearing. The witnesses have been forthright, they have been honest with us. They have brought out some problems that probably we had not heard in other parts of the country. The directors and managers of the veterans programs here in Tennessee seem to me to be sincere in their jobs and we have learned a lot. We would like to thank especially the veterans organizations and veterans themselves for being here today.

You have got to get out of Washington to find out what is going on in the country and I appreciate you gentlemen and ladies taking up your time and being here this morning. We have built up a record and so this has been a profitable morning for our committee and this information will be most helpful.

Do any members have any comments before the chairman closes this hearing?

[No response.]

Mr. **Montgomery**. Well, on behalf of the subcommittee, I now declare this subcommittee hearing hereby adojurned.

[Whereupon, at 12 noon, the subcommittee adjourned.]

APPENDIX

PREPARED STATEMENT OF HERBERT S. ARNETT, DIRECTOR, VA MEDICAL CENTER, MEMPHIS, TENN.

I want to thank this Subcommittee on Oversight and Investigations of the House Committee on Veterans Affairs for the privilege of testifying.

In relation to the two subjects of this hearing "admitting practices and the quality of health care delivered by the Veterans Administration in Tennessee," I will try to furnish a brief overview. The Memphis VA Medical Center admits approximately 18,000 veterans to inpatient care annually. We receive annually approximately 38,000 applications for care. Of this 38,000 approximately 76 percent are found in need of care and are either admitted to inpatient program or placed in an ambulatory care clinic program. Our admission practices are administered as authorized for legal and medical eligibility by Congress. No legally eligible veteran found in need of care has been refused care at our medical center.

We are assigned and funded for 705 average daily inpatients and 150,300 outpatient visits. We have averaged 713 inhouse the past month. The average number of outpatient visits for the last three years has been 158,688 which indicates that we are treating more outpatient veterans than our assigned workload. Non-service-connected or ambulatory care veterans, when stabilized, are referred back to the community for their health care. There are 245,000 veterans in our primary service area which covers 19 counties in Tennessee, 25 counties in Mississippi, 8 counties in Arkansas, and 1 county in Kentucky. Our Spinal Injury Service treats patients from throughout the Southeast and Southwest.

We deliver quality health care to a large number of veterans. We accomplish this through a multi-specialtied and multi-disciplined staff that offers numerous services to promote the well-being of the veteran patient. From a medical point of view, there are 77 board certified specialists representing a vast array of specialties. These specialists are responsible for a number of health care programs which significantly contribute to the health of the veteran. Open heart surgery, renal dialysis, geriatrics, alcohol and drug rehabilitation are but a few examples of the programs offered. The Intensive Care Unit and Nursing Home Care Units are some of the finest units of their kind in the Mid-South.

Affiliation of the Memphis VAMC with the University of Tennessee Center for the Health Sciences greatly increases the quality and amount of health care rendered to veterans through the promotion of higher standards for patient care. Although the primary mission of this VAMC is quality health care to veterans, 1,400 allied and medical personnel received a significant part or their training through the various programs offered at this VAMC. This, in turn, enriches the health care of the veteran.

In addition to the quality medical care administered at the Memphis VAMC, a variety of other disciplines are provided. For example, social services, rehabilitative services, psychology, chaplaincy, hearing and speech pathology are provided to improve the veteran's health status.

A Class II Emergency Room is provided to render accute critical care, and less critically ill veterans are triaged by means of a multi-disciplined health team to determine how best to meet the veteran patient's needs. This, many times, requires consultation which is provided by the appropriate subspecialty. We were accredited by the Joint Commission on Accreditation of Hospitals for two years this past December.

We feel that the quality of health care delivered by the Memphis VAMC equals or exceeds any health care delivered within the Mid-South area.

Taking into consideration our budget constraints, we will continue to administer all programs in health care that are authorized by Congress.

Thank you for inviting me, and I will respond to any questions.

PREPARED STATEMENT OF JOSEPH C. SNELLING, DIRECTOR, VA MEDICAL CENTER, MOUNTAIN HOME, TENN.

Mr. Chairman and members of the subcommittee: I appreciate the opportunity to add my comments to those of my colleagues. I will by necessity restrict my comments to the status of VAMC, Mountain Home, since I am not in a position to speak for the other facilities.

Since 1977 there have been significant changes in the quality of health care at Mountain Home as well as the method by which the medical care is delivered. In the fall of 1977, the Quillen-Dishner College of Medicine of ETSU admitted the first class of 24 students, as permitted and authorized by the Teague-Cranston Act. Shortly before that time, the medical school began the process of recruiting a faculty of outstanding physicians who for the most part devoted at least part of their time to the care of veterans at the VA Medical Center, Mountain Home. This growth in the professional staff has continued until we presently have 55 full- and part-time physicians on our staff. These academically oriented physicians have added new dimension in specialized treatment in GI, cardiology, infectious disease, neurology, etc. This specialized care was not available at Mountain Home prior to 1977. In addition, we have presently 23 residents in training at Mountain Home in general surgery and internal medicine as well as fellowships in GI and cardiology. These numbers will increase to 39 in July 1982.

In part, the improved quality of care now being delivered at Mountain Home is reflected in the expanded scope of our services as I just mentioned; however, we also point with a great deal of pride to some other generally accepted indicators of quality such as the full accreditation received from the Joint Commission on Accreditation of Hospitals.

Our laboratory and pathology services are also fully accredited by the College of American Pathologists, making it the only such service in the Tri-Cities to receive accreditation from CAP.

In addition, our facility is surveyed biannually by a team from our central office as part of a systematic external review program. Our most recent SERP visit occurred in May of 1981 with good results.

These agencies and bodies review not only programs but also physical facilities, and while we are proud of the overall outcome in each instance, we are certainly not without deficiencies, many of which are physical and structural in nature.

Most, but not all, of our physical plant deficiencies will be corrected by construction now underway or contemplated, and I would like to now present a brief description of the major construction projects at Mountain Home. I should preface these remarks by saying that all buildings on the grounds at Mountain Home are listed on the national registry of historic places since most were erected in 1903 and none were built after 1938.

All of these buildings are beautiful, in fact, but certainly inadequate for the practice of modern medicine. Because of already existing fire and safety deficiencies as well as the absence of adequate patient privacy (wards are all open-bay type) we feel that current facilities will not support medical care needs in the near or distant future. Consequently, a $10.6 million clinical support building containing 90,000 gross square feet and 6 new X-ray rooms, 5 operating rooms, 7 surgical recovery rooms, new sterile supply facilities, and several outpatient examining rooms, and a new laboratory suite is now under construction, with completion anticipated in 1984.

Also, now under construction with an anticipated completion date of 1983, is a medical school classroom building which will offer office space, biophysics lab and medical school library for a cost of $13 million.

Neither of these buildings will contain facilities for patient occupancy and, as a result, the problems associated with patient privacy and logistics due to our multibuilding institution will not be resolved.

Much of our recent success can be attributed to the infusion of significant funding increases. This year, fiscal year 1982, an additional $1.3 million was provided to Mountain Home over and above the usual increases for inflation and increased usage. These additional funds were provided by our central office after a comprehensive review of our needs and financial status in January of 1980. These funds were awarded primarily in recognition of the inevitable cost increases associated with a medical school affiliation and the resultant broadening of scope in treatment, education and research. Increased drug costs, lab and X-ray utilization, expansion and use of more sophisticated diagnostic procedures, such as CT scans and nuclear medicine tests also had a significant impact on operating costs. These explosive cost increases are closely related to the growth of the Quillen-Dishner College of Medicine. Further expansion and development is logical and expected since the college has not yet reached its full potential of seevnty-two students per class. We also expect further growth of our own capabilities at the VA at Mountain Home to allow us to fully support the medical school. For example, we have intentions of developing a state-of-the-art surgical recovery room commonly associated with an up-to-date medical center. Our recovery room is presently staffed with only one nurse and operated eight hours per day for five days per week, which is about half of the staffing time needed. We have recently activated a nuclear medicine service.

However, in order to realize our full patient care and teaching potential and research capabilities, we must develop new treatment capabilities such as a cardiology step down unit, neurosurgical capability, as well as dermatology and gerontology specialties. These additional direct medical care support units will not come cheaply and while I know that our list of needs seems endless, it is because we have had a great deal of ground to make up in an attempt to provide the veterans in our primary service area modern medical care and to reach parity with the longstanding medical school affiliations enjoyed by other VA medical centers in Tennessee.

Due in great part to our association with the Quillen-Dishner College of Medicine, our medical center has evolved from a bandaids and bruises primary care facility to a secondary care facility which is on the verge of becoming a tertiary state-of-the-art medical center with a vast array of medical and surgical specialties and subspecialties.

Mr. Chairman, I would like to use my remaining time to make a few brief remarks about the admitting practices at Mountain Home.

Essentially our admitting practices are the same as all VA medical centers because we are governed by laws established by Congress and VA regulations issued as a result of those laws.

An applicant for admission to our facility must first meet legal entitlement requirements, then the applicant is provided a thorough medical evaluation to determine his/her medical needs.

If hospitalization is indicated, the veteran is admitted for inpatient care. If treatment is indicated but hospitalization can be obviated by outpatient care, the patient is given necessary treatment on the initial application and requested to accept return appointments until his/her condition is stabilized. This type treatment is time limited for non-service-connected treatment until the veteran is stabilized so that a referral can be made to a private physician—generally within 90 days of the initial visit. Within this 90 days, a decision can be made by the physician as to whether the patient is no longer in need of care, is stable enough to go to a private physician, or requires admission.

There are those instances wherein the non-service-connected applicant is ill but not to the degree that the physician feels hospitalization will result if left untreated. When this occurs, the patient is not offered treatment of any kind but is seen by a social worker who attempts to resolve the applicant's problems through community resources.

In recent months we have found that many veterans who have not heretofore used our facilities are now doing so. This we attribute to the general economic climate and unemployment in particular.

In summation, it is our continuing policy to provide all eligible veterans with prompt, compassionate and high quality medical care, and I do appreciate this opportunity to provide my comments to you, Mr. Chairman.

PREPARED STATEMENT OF LARRY E. DETERS, DIRECTOR, VA MEDICAL CENTER, NASHVILLE, TENN.

I appreciate the opportunity to appear before this committee to discuss the quality of care and the admitting practices of the Nashville VA Medical Center. It is the goal and the mission of this medical center to provide quality health care to all eligible veterans in accordance with existing law and regulations.

A copy of these policies is included as an attachment to my written statement. Applications for care are processed in accordance with the priorities as mandated by 38 USC and the Veterans Administration.

During recent years, there have been increasing demands on this medical center. It is my belief that some of the factors creating these increased demands include: (1) an increasing population in Middle Tennessee (up 16 percent since 1970); (2) a very high unemployment rate (over 12 percent) in our primary service area; and the increasing age of the veteran population resulting in more complex and frequent health care needs. During the year the number of new applications per day has tripled! These veterans have never before applied for care at this medical center. Many have lost their employer paid health benefits when they were laid off and their only option is to seek care from the VA.

In spite of budget constraints, our statistics for 1981 showed that of a total of 24,971 applications received, 22,395 or 93.9 percent received treatment. We had the highest community nursing home census since the inception of that program in 1974; an increased turnover rate (307.4 percent); a 79 percent occupancy rate and a reduced length of stay of 14.9 days. Outpatient visits to our medical center have continued to increase because of the health care needs of our veterans. During 1981, there were 135,101 outpatient visits to this medical center and our outpatient clinics in Knoxville and Chattanooga.

The quality of our professional staff is outstanding. Our physician staff of 74 includes 56 with faculty appointments. Fifty-five of our physicians are board certified. Our nursing staff includes 23 nurses prepared at the master's degree level and 62 with baccalaureate degrees. A total of 38 nurses have special certificates in areas such as critical care, dialysis, operating room, emergency department and adult nursing. In addition to our medical residency program, we have allied health students from 38 colleges and universities. At the present time, we train approximately 87 students from these programs. These training programs assist us in maintaining an active and effective hospital and stimulate our own staff to maintain high standards of care. Despite our active role in medical and allied health education and research, our main objective is high quality patient care.

We provide a wide range of specialized medical programs, including: open-heart surgery, kidney transplantation, dialysis, alcohol abuse, cardiac catheterization, nuclear medicine, plus our intensive care unit capabilities. The satellite outpatient clinics in Chattanooga and Knoxville enhance referral patterns from those communities.

In my opinion, there is a high quality of care provided at the Nashville VAMC by a very professional staff. The care is continually monitored through a sophisticated quality assurance program totally supported by the medical staff. In addition, we require systematic internal reviews by every service in the medical center on an annual basis.

Since 1980, we have had three external reviews. These include the JCAH in December 1980, which resulted in a full 2-year accreditation; a Systematic External Review Program in September 1980, resulting in all services being rated as good, very good and excellent; and an American Legion Field Visit in August 1981 which described the support services as excellent and concluding that good patient care is being provided.

Again, thank you for the opportunity to appear before you. I will be glad to answer any questions.

Chapter 4. Admissions—Hospital and Domiciliary Care

SECTION I. GENERAL

4.01 Basic policy

a. All applications for hospital treatment or domiciliary care received by the VA will be given prompt attention. Action will be completed on applications received by mail within an average of 2 working days. Applicants who appear in person will be given a medical examination promptly to determine need for care. Applicants who have been examined by the admitting physician and who have been previously scheduled for admission, either from OPT-PBC or from the waiting list, will report directly to the admission activity and will be taken immediately to the ward with previously prepared medical records. Re-examination by the admitting physician is unnecessary. After the examination of the applicant or the evaluation of mailed in application, one of the following actions will be taken: (1) A decision will be made to admit it once or place on an ambulatory care status to obviate the need for hospital treatment, (2) applicant who is physically present will be scheduled for admission and provided a reporting date if a bed will be avilable within 15 calendar days (veterans who mailed in their applications to the facility will be advised in writing), (3) applicants will be placed on PBC (pre-bed care), (4) placed on the waiting list, or (5) applicant will be rejected as not in need of hospitalization. If a conclusive determination cannot be reached on the day of the examination, the patient will be admitted for observation or scheduled for admission and placed on PBC status.

404 Admission of applicants referred by physicians

b. Admission responsibility, and hence the final disposition of all cases, rests ultimately with the physician assigned this responsibility at the facility where the application is received. Field facilities which initially receive applications or requests for hospitalization are responsible for furnishing needed care or making necessary arrangements with other VA facilities for admission. This responsibility often involves critical life and death decisions and is to be regarded with the utmost gravity. The effectiveness of the VA medical care system is affected to a large extent by the professional skill and judgment with which this responsibility is discharged. Applicants referred for hospital admission by this responsibility is discharged. Applicants referred for hospital admission by a clinic physician will not be re-examined unless an interval of time has elapsed which would warrant re-evaluation.

Priority for Care

a. Those persons requiring immediate attention will be provided emergency care without regard to priorities.

b. Enrollment in, or care following enrollment in an outpatient program will be based on a professional determination of the need for care, and the applicant or patient will be scheduled and/or seen according to the following priorities and in the sequence indicated within these priorities.

c. Priorities Ia, b and c, and priority II are mandated by 38 U.S.C. 612(i). Priorities III through VI are established by departmental policy.

PRIORITY I

a. Veterans requiring care for service-connected disabilities or for disabilities incurred in line of duty for which they were released or retired from the active military, naval or air service. (This category also includes Spanish-American War veterans requiring care for any disability.)

b. Veterans with a service-connected disability or disabilities rated at 50 percent or more.

c. Veterans with service-connected disabilities or retired for disabilities incurred in line of duty, requiring care for non-service-connected disabilities.

PRIORITY II

POW's for admission and outpatient treatment. Agent Orange and radiation exposure.

PRIORITY III

Veterans in receipt of increased pension or special allowance based on the need of regular aid and attendance or by reason of being permanently housebound, or who, but for the receipt of retired pay, would be in receipt of such increased pension or special allowance, World War I and Mexican Border Period.

PRIORITY IV

a. Compensation or pension examinations and examinations for VA insurance purposes.

b. Veterans entitled to vocational rehabilitation training who are receiving or in need of such training, and medical services are determined necessary for any of the reasons given in VA Regulation 6036(B).

PRIORITY V

a. Non-service-connected veterans requiring post-hospital care (OPT-NSC).

b. Non-service-connected veterans requiring PBC (pre-bed care).

PRIORITY VI

a. Non-service-connected veterans requiring care to obviate the need for hospitalization.

b. Former members of the armed forces retired from the service on the basis of length of service who are to be provided outpatient care as beneficiaries of the armed forces.

PRIORITY VII

a. Persons treated under sharing agreements.

b. Beneficiaries from other Federal agencies, except as described in Priority VIb.

c. Veterans of nations allied with the United States in World War I or II receiving medical care under the authority of 38 U.S.C. 109(a).

External Reviews

AMERICAN LEGION VISITATION REPORT; AUGUST 31–SEPTEMBER 4, 1981; EMIL N. NASCHINSKI, NATIONAL FIELD REPRESENTATIVE

Support services described as excellent. Concluded that good patient care is being provided at NVAMC.

SYSTEMATIC EXTERNAL REVIEW PROGRAM; SEPTEMBER 22–26, 1980

Adjective Rating by Service: Excellent, 11; very good, 11; good, 8; acceptable, 0; unacceptable, 0.

JOINT COMMISSION ON ACCREDITATION OF HOSPITALS; DECEMBER 9–11, 1980

"You are to be complimented on the quality of services you are providing . . ."

PREPARED STATEMENT OF ROBERT S. PEPIOT, DIRECTOR, VA MEDICAL CENTER, MURFREESBORO, TENN.

1. Two attachments are provided for background information pertaining to our medical center. Attachment 1 is our admitting policy and attachment 2 is a copy of our mission statement which describes our geographic area and the types of patients served and treatment we provide.

2. Circumstances affecting our ability to provide care are as follows. On September 1, 1980, we were required to close Buildings 5 and 6 for modification which included fire and safety and patient privacy requirements. Total loss of operating beds in the two buildings was 138. This happened at a time when we were running above 90 percent occupancy, and, thus, approximately 125 veterans were affected. To relieve the bed crunch at that time, veterans who could benefit were placed in residential care homes; others were placed in community nursing homes; and others were transferred to VA Medical Centers at Lexington, KY; Tuscaloosa, AL; and Augusta, GA. From September 1980 to mid-1981, this hospital was only able to admit emergencies.

3. On April 1, 1981, Ward 6G was closed because of demolition that was underway on the floors above in Building 6. This further compounded our problem with availability of beds. Ward 6G became operational again on February 1, 1982.

4. Murfreesboro is scheduled for additional building closures for modernization and to meet compliance with patient privacy and fire and safety requirements. Our operating beds during this time will be limited to approximately 550. This will run through fiscal years 1983 and 1984. By fiscal year 1985, Buildings 3 and 7 should be fully operational, and the fire and safety project in Buildings 1, 8, and 9 should be completed. Beginning in fiscal year 1986, a new 120-bed nursing home care unit should become operational. In fiscal year 1986 or early 1987, we should be operating 730 beds with a 120-bed nursing home care unit.

5. The quality of care administered by this medical center, I believe, is highly satisfactory. We have been able to augment our medical staff with board-certified physicians. We currently have 11 board-certified physicians (five in Psychiatry, two in Medicine, and four in other categories).

6. The outpatient services have also been upgraded and we currently have 11 clinics which provide a well-rounded program to meet the needs of the veteran patients. The outpatient clinics are relatively new at our facility, some having been started in fiscal year 1981 and others in early 1982.

7. We have two funded psychiatry resident positions. In addition, we have four medical residents furnished by Meharry Medical College, with whom we have an affiliation, which is located in Nashville, TN. We also have approximately four medical students on any day during the week. All of this has helped to upgrade the quality of care that is delivered at this facility.

8. The Mental Hygiene Clinic which is an outpatient program has also been effective in maintaining our patients in a community setting. We have a board-certified psychiatrist who heads up this program.

9. The residential care program is a very large one at this facility. We have veterans placed in 49 homes for a total of 316 veterans being served in this program. All of these homes are within a 75-mile radius of this hospital. This is an extensive program administered by our Social Work Service. All homes are inspected by the State as well as the VA. The average age of the veterans placed in this program is 69.2 years. Consequently, there are increasing medical problems which then impacts on this medical center.

10. The contract nursing home program currently in operation is funded for 33 placements. The VA, in the past, has contracted for six months; then, prior to the expiration of that contract, the State Medicaid Program assumed responsibility or else the family, through their resources, took over. Our ability to place beneficiaries in community nursing homes will be in serious trouble if the State Medicaid Program resources dwindle. Another problem associated with the contract nursing home program is locating a contract nursing home near the family because of the demand for such beds in the state of Tennessee. There will be increasing pressure to return the veteran beneficiary to an intermediate care bed as state resources decrease and demand for beds increases.

Attachments.

I. ADMISSION POLICY

A prompt examination will be accomplished on all applicants for hospitalization who appear in person. Determination of whether an applicant requires hospitalization entails the exercise of sound clinical judgment. Reasonable doubt concerning the need for hospitalization will be resolved in favor of the veteran.

The decision concerning need for care will be based solely on the medical needs of the applicant. Chronicity of illness, nonavailability of bed or facilities, education and research interests, and other extraneous factors will not control the decision to admit a veteran.

Eligible applicants who are in need of hospital care will be admitted. If appropriate staff and facilities are not available, arrangements will be made for transfer to the appropriate facility within the Medical District or to the nearest VA facility with staff and facilities suitable for the treatment or evaluation of the veteran's condition.

Veterans will be admitted according to the following priorities:

a. Medical emergent—immediately.

b. Admission required for service-connected disability—immediately, if possible, but in any event within 5 calendar days.

c. Nonemergent patients requiring hospitalization for nonservice-connected disability—as beds become available, in accordance with waiting list policy.

Applications for hospitalization received by mail will be acted on within an average of 2 working days.

Ambulatory care (outpatient treatment) may be furnished to veterans who are eligible for care and who do not otherwise have entitlement to outpatient care when (1) an application is made for hospital care, and (2) a medical determination indicates that such care is reasonably necessary but the required care can be provided on an ambulatory basis. This determination must be made by the examining physician or treating physician and should be based on his professional judgment that the medical services to be provided are necessary to treat a condition(s) which would normally require bed care or which, if untreated, could reasonably be expected to require such care in the immediate future. This would not, however, cover routine treatment of chronic conditions which do not normally require inpatient care such as daily insulin injections for diabetes, administration of antihypertensive drugs, etc. Medication and medical supplies (excluding prosthetic items) necessary to accomplish the treatment objective may be furnished. Ambulatory care will be terminated when the patient's condition has improved or stabilized to the extent that further care is no longer required to satisfy the purpose for which it was initiated.

II. MISSION STATEMENT

Major functions and levels of care

The VA Medical Center, Murfreesboro, TN, is a 730-bed health care facility engaged primarily in the care and treatment of psychiatric and intermediate medical patients, including their intercurrent medical problems. A full range of psychiatric care, including intensive, acute, and extended, is provided as well as a 60-bed comprehensive alcohol rehabilitation program. The Intermediate Medical Service provides primary, as well as some secondary, levels of care which includes a medical intensive care unit, a respiratory care unit, and stroke rehabilitation unit, and necessary diagnosis/treatment for intercurrent medical conditions. A Rehabilitation Medicine Service, as well as other ancillary services, provides a full range of services in support of the two primary services. The Medical Center complex also houses a 48-bed nursing home care unit. Services delivered by the various disciplines are interrelated for maximum efficiency.

Patients requiring tertiary care or extensive diagnostic and/or treatment services in the various medical and surgical specialties are transferred to the VA Medical Center, Nashville. The VAMC, Murfreesboro, provides long-term psychiatric care and extended medical care for VAMC, Nashville, patients.

Philosophy

The veterans serviced by the Murfreesboro VA Medical Center will be provided high quality psychiatric and intermediate care by compassionate and caring employees. Special emphasis will be provided for geriatric treatment modalities throughout all programs. A close working relationship will be maintained with Nashville VA Medical Center.

Characteristics

The VA Medical Center is located in Rutherford County near the geographic center of the State and is easily accessible by private transportation. It has traditionally served as a long-term resource for veterans throughout the southeast. The 1980 Patient Origin Study showed discharges to 85 counties in Tennessee and 21 different states.

The Murfreesboro facility was constructed in 1939 with the last patient building being activated in 1947. The physical facility has been well maintained and the campus-like grounds contain ample space for expansion. A series of construction projects planned in the 1980's will modernize all patient sleeping areas by 1990.

The Murfreesboro Medical Center has one of the largest residential care programs in the VA system. Over 300 former patients are located in numerous private residential care homes. Strong medical support from the Medical Center has been provided to keep this program operational, including rehospitalization when needed.

Relationships

The VAMC Murfreesboro has occupied the position of having the largest payroll of any employer in Rutherford County for nearly 40 years. The community and its civic leaders are very much concerned with the operation of this facility.

There is another medical facility, Rutherford Hospital, in Murfreesboro but contact is minimal because of the different roles of the two facilities. Strong medical support is obtained from VAMC Nashville which is located within a 45-minute drive.

Clientele served

Medical centers that are primarily psychiatric facilities do not have a defined primary service area (PSA). In the Bed Projection Study for 1990, four contiguous PSAs of general medical and surgical facilities were defined as Murfreesboro's PSA. These facilities were Nashville, Altanta, Mountain Home, and Memphis, and veterans from these four catchment areas accounted for 85 percent of the demand on the Murfreesboro health care facility. In addition to the catchment areas, veterans from north Alabama, west Carolina, north Mississippi, and south Kentucky have traditionally used our facility.

Over 1,100,000 veterans lived in this catchment area in 1980. The projection for this area in 1990 is 996,000 veterans.

The Murfreesboro VA facility has been actively involved with the geriatric veterans. Over 30 percent of the veterans hospitalized on September 30, 1981, were 65 years of age or older. In fiscal year 1980, over 40 percent of the discharges were 55 years of age or older. This role of providing care to geriatric patients has been projected as increasing through 1990. The bed planning document included a projection that the veterans of 65 years of age or older would increase in the Murfreesboro PSA from 81,000 in 1980 to 227,000 in 1990 or an increase of 180 percent. This same study projected veterans 55 years of age or older would increase from 337,000 in 1980 to 387,000 in 1990 or an increase of 15 percent. Using the 1980 discharge rates per 1,000 for the 65 years of age or older veterans, with the 1980 length of stay for 65 years or older veterans and the 1990 projection of 65 years of age or older, one projects that over 50 percent of the 730 beds in 1990 will be needed for veterans of this 65-and-older age group.

All these projections were based on the more conservative national projections. A recent projection on Tennessee growth obtained in the August 24, 1981, issue of the Tennessee Journal predicted the Tennessee growth rate will be more than 50 percent above the national rate until the year 2000. This is a continuation of the trend set in the 1970's when the Tennessee compound annual average population growth was 1.58 percent compared to the national average of 1.09 percent. These statistics, coupled with the fact that Rutherford County had a growth rate of 41.4 percent in the 1970's, indicate that projections on demand based on national averages will be on the low side.

Academic affairs

The Medical Center is affiliated with Meharry Medical College and maintains an active residency training program. Two resident positions are funded by VA Central Office. Four additional residents are assigned from Meharry on W.O.C. status, and medical students are rotated through Psychiatry and Medical Services. In addition, there are allied health training programs in various disciplines with other schools.

PREPARED STATEMENT OF COMMISSIONER WILLIAM H. RODEN, TENNESSEE DEPARTMENT OF VETERANS' AFFAIRS

Thank you for the privilege of appearing before this distinguished subcommittee. My name is William H. Roden. I am Commissioner of the Tennessee Department of Veterans Affairs. As a member of Governor Lamar Alexander's Cabinet, I bring you warmest greetings from the Executive branch of State Government in Tennessee and offer the services of my office to assist your Subcommittee in any way possible.

As Commissioner, I am honored to serve and work with more than 542,000 veterans and their dependents who currently live in Tennessee. My remarks shall be directed toward what I perceive to be the major concerns of veterans in Tennessee with regard to the topics you have selected for this hearing, namely, (1) the admitting practices and the quality of health care delivered by the Veterans Administration in Tennessee, and (2) the quality of service provided by the Nashville Veterans Administration Regional Office.

During my tenure as Commissioner, I have worked with seven different directors of the four VA Medical Centers in Tennessee, and with one director of the Nashville VA Regional Office. Mr. Chairman, the VA Medical Centers and the Nashville Regional Office are in very good hands as far as management is concerned. This was the case when I came and it continues to be so today. I must emphasize the sensitive and responsive nature of these Directors and their entire staffs. Any inquiry or suggestion from my office to them has been received and acted upon immediately. These actions have evidenced great concern for the veteran and the highest respect for ethical and professional standards.

The admitting practices of all VA Medical Centers and Clinics in Tennessee appear to be consistent with the Veterans Administration priority criteria for such admissions. In general, veterans have accepted those priority criteria and have no quarrel with the manner in which they are administered; however, the nonservice-connected veteran under 65 years of age who is chronically ill must be denied admittance to a VA Medical Center in many cases. This is due to the limited capacity of the particular hospital, which is a reflection of budgetary limitations. This problem is becoming a major concern for many veterans in Tennessee.

The quality of health care rendered by the VA in Tennessee is second to none. Once a veteran is accepted for admission or treatment at a VA medical facility, there is a general feeling among veterans and their families that the care/treatment are as good as can be provided anywhere. A very major concern for veterans in this regard is the abolishment of the over-the-counter drug program of the nonservice-connected veteran patient.

It provides little comfort to the veteran patient to have a medical diagnosis made, a medicine prescribed for the condition, and then find no means to secure that medicine due to the lack of funds on the part of the veteran. It would seem logical and reasonable that if a veteran is to be "treated" at a VA medical facility, then the veteran should receive all that is necessary to effect that prescribed treatment. Very careful consideration should be given to re-establishing the over-the-counter drug program for the nonservice connected veteran patient.

With more than 215,000 World War II veterans (average age—62 years) and 10,000 World War I veterans (average age—86 years), living in Tennessee, the future needs for medical services is fast becoming a major concern to these veterans. This need can be met by expanded geriatrics research, education, and clinical programs. The VAMC at Murfreesboro is a logical place for such an expansion due to the nature of the majority of the patients being treated there, and the prime interest of the medical staff in geriatrics, and the affiliation with a medical school which is emphasizing geriatrics as a specialized field of medicine.

With a large population of aging veterans, a full capacity of patients in VA nursing care facilities, and many other veterans needing some degree of skilled nursing care, it has become evident that some provision must be made for additional nursing facilities and care. Even though there is a grant program available through the Veterans Administration for the Federal Government to share in the cost of State-owned/operated nursing/domiciliary facilities, I personally believe that there is an urgent need for Congress to take the initiative in seeking new incentives for State governments and nationally chartered veterans organizations to work together in assuming equitable responsibilities for providing nursing home and domiciliary facilities and care for legal State-resident veterans.

One of the factors that affects admissions capabilities and medical/health care in Tennessee VA Medical Centers is local competition for qualified medical personnel. This is especially true with regard to nurses. If a VAMC has to close beds due to a lack of critical care staff nursing personnel caused by inability of the VAMC to compete with local hospitals, then the local VAMC director must have the flexibility to meet the competition so as to keep the critical care unit operative. Lack of such management flexibility will quickly and adversely affect the quality of care at the local VAMC. This matter can be handled within the VA Central Office, it would seem, Mr. Chairman. I strongly urge that such a policy of local flexibility be considered.

Mr. Chairman, the quality of medical/health care rendered by the VA in Tennessee is not the major concern of our veterans; rather, we are concerned about the quantity of such services that are and will continue to be available to eligible veterans. When less than 1 percent of the nonservice-connected patients who are treated at our VAMC's state an ability to pay for medical services, the matter of quantity becomes a prime concern for an aging veteran. More than 225,000 of Tennessee's living veterans are 60 years of age or older and the relatively low income of Tennessee families compounds this problem.

The entire staffs of the VAMC's and the VARO have been most helpful in the work of the Select Committee on Veterans Affairs of the Tennessee House of Representatives and staff personnel from the Tennessee Department of Veterans Affairs, with problems related to Agent Orange. These VA personnel have met with the Select Committee, TDVA personnel, and concerned veterans in an effort to share latest scientific information and to guide affected veterans in their quest for answers to problems created by Agent Orange. Insofar as I know, any Tennessee veteran who wished to be examined or receive information regarding Agent Orange has been served through these cooperative endeavors.

The Nashville Regional Office continues to be most outstanding, in my opinion, in the timely handling of claims for benefits. This is evidenced by the fact that the pending workload of claims in the Adjudication Division has averaged just over 3 days during the last several months, running from a low of 1.4 days in August 1981, to 5.6 days at the end of December 1981, during the IQ processing—a very heavy workload period normally. The other divisions seem to be keeping up with the demands made on them, with the possible exception of the Vocational Rehabilitation and Counseling Division where the number of pending cases was 130 in late January 1982. This may be due to the need for additional counseling psychologists, but I suspect that it is more due to an increase in the number of applicants due to current economic conditions.

Mr. Chairman, the VA Nashville Regional Office serves more than 1,500,000 persons in Tennessee and does its job well. Tennessee veterans are appreciative of these services and the genuine concern that flows from the Director and his staff. The major concern of veterans in Tennessee is that the VARO will continue to operate in Nashville and will not fall victim to some ill-conceived plan of "regionalization" such as that recently under discussion in some circles around Washington. Tennessee veterans want the VARO to remain in Nashville!

Finally, Mr. Chairman, the one fact that underscores the validity of our concerns regarding future VA medical and administrative services in Tennessee is the 17 per cent growth in Tennessee population shown by the 1980 Census. More and more people are moving to Tennessee upon retirement, possibly because of our location on the edge of the Sun-belt, and the lower costs of living as compared to some other sections of the Nation. Also, many veterans have lost jobs and resulting loss of medical insurance. These factors appear to be showing in the statistics regarding applicants/patients in the VA Medical Centers and Clinics and the needs for certain services from the VA Regional Office in Nashville.

This concludes my statement, Mr. Chairman. I thank the Subcommittee for its generous work in behalf of veterans and offer again the services of my office in any way possible.

PREPARED STATEMENT OF DAN JACKSON, PRESIDENT, VIETNAM VETERANS ASSOCIATION OF TENNESSEE

Today's controversy concerning the exposure of Vietnam veterans to toxic substances during combat has focused almost exclusively on the toxic chemical dioxin, better known as Agent Orange. Although considerable adverse media space and some time has been devoted to the disturbing allegations made with regard to the health hazards experienced by Vietnam veterans as a result of their exposure to the herbicide, veterans across the state feel their case is being ignored by the government.

Aware that most veterans programs lie within the administrative purview of the Federal Government, the Select Committee on Veterans Affairs, nonetheless, felt it necessary to examine closely the concerns of Tennessee Vietnam veterans. Throughout the summer and fall of 1981, the committee conducted a series of two-day hearings in Rogersville and in the Nashville/Donelson area. From the initial testimony the committee learned that the problems encountered by the State's veterans are of enormous magnitude and will demand a concerted and coordinated effort by Federal and State governments to maintain the quality of programs and services traditionally awarded to those who have "borne the battle."

In response to public concern and the controversy surrounding herbicides used in Vietnam, the committee decided to examine the issue and give Tennessee Vietnam veterans an opportunity to speak-out on past experiences and perceived present physical and psychological problems. The essence of the problem is the fact that veterans of the Vietnam war era are experiencing health problems they feel are a result of their exposure to potentially dangerous herbicides. Unfortunately, the federal government has no answer to the effects of agent orange, because at present there is no scientific evidence to link agent orange exposure to anything except a skin irritation know as chlor-acne. From the initial testimony our committee learned that veterans of the Vietnam war have been experiencing health related problems which they feel are linked to exposure to agent orange. Of those veterans examined at VA medical centers, many have reported suspected herbicide related problems including cancer, birth defective offspring, liver dysfunction and a number of physical and psychological disorders. Veterans in both middle and east Tennessee testified that they have fathered children born with birth defects such as spina bifida and hearing loss. Others testified they were victims of cancer, liver damage, kidney dysfunction and delayed stress syndrome. Many feel their wives are affected because of the large number of miscarriages and/or hysterectomies that have resulted when the woman became pregnant.

Another issue we examined is the lack of medical assistance for veterans in regard to the availability of medical service for agent orange victims. Instances of discourteous staff at the veterans' medical centers and the lack of care for children born with birth defects are other concerns.

With the technology, research and laboratory facilities available in the United States today, veterans cannot understand why tests to determine the real significance of agent orange or dioxin exposure to humans have not been conducted. Animals tend to be the prime target for such laboratory research, however, doctors admit that different species react differently to chemical exposure and no direct correlation, between the two, can be drawn. With chloracne being the only visible symptom, tests on animals show liver dysfunction and nervous system disorders. Dioxin itself is teratogenic, causing severe deformation of fetuses in animal research, however no conclusion has been drawn as to its effects on humans.

Medical records and their whereabouts constitute another problem area. Veterans have testified that they have tried repeatedly without success to obtain their medical records. Many desire to see for themselves the medication they have been prescribed in an attempt to relate past medical treatment to some of the physical and mental problems they are experiencing today.

WHAT YOUR GOVERNMENT IS DOING ABOUT AGENT ORANGE

The President of the United States, in his recognition of the trust this Nation holds in behalf of those who have served our country in time of war, and in recognition of the heavy questions that eat at the minds of many who have served, has publicly and forcefully reaffirmed and reinforced the goals with an agent orange working group now on cabinet level. Special consideration to the concerns of Vietnam veterans over agent orange have been and will continue to be given. The fiscal year 1982 budget contains a large increase in funding for the continued study of agent orange. This working group has initiated research efforts designed to find answers to many of the questions surrounding agent orange that have been raised. These efforts include the birth defects study being conducted by HHS Centers for Disease Control, the Ranch Hand Study being conducted by the Air Force, the epidemiological study being planned by the Veterans Administration pursuant to Public Law 96–151 and the Compilation of HHS National Institute of Occupational Safety and Health of a national registry of workers exposed to dioxins. Each of these research activities being conducted under the overall guidance of the working group are to be continued without interruption or delay.

As a result of our hearings in the State of Tennessee, we have been informed about the problems of our states' veterans. The testimony has been recorded and will be laid in the lap of Congress in April of this year when selected members go before the Congressional committee to testify on behalf of the veterans in Tennessee. From the testimony gathered through our meetings, the Select Committee on Veterans Affairs has determined the following recommendations.

We:

(1) Recommend that the budget for the Veterans Administration be fully funded to allow the VA to move in a more expeditious manner in research and laboratory testing relative to possible adverse health effects in those veterans exposed to potentially dangerous herbicides.

(2) Recommend that in this money appropriated by Congress, that the examinations presently being administered by the VA be fully funded to allow those veterans who seek this examination for conditions related to agent orange be extended this opportunity.

(3) Recommend that every effort be put forth by the VA to upgrade the level of communication between veterans and VA medical personnel and employees to establish more positive rapport with the veterans who seek assistance so as to reflect a more sensitive attitude on the part of the VA and make the veterans initial experience at a VA facility more pleasant.

I firmly believe that the Veterans Administration must take a more aggressive stance in addressing this issue.

I believe that there must be a concerted and coordinated effort by the federal and state governments to maintain the quality of programs and services traditionally awarded to those who have borne the battle.

I firmly believe that the agent orange question involves a moral obligation to care for our nations veterans and a determined effort by Congress to appropriate such money needed to research the mysteries of herbicide technology.

Finally, I believe the problem of agent orange is a major concern of state government. We consider veterans "special people" and feel that "*we*" veterans should be treated accordingly. The problems are simply a product of a steadily increasing demand for services on a government system that cannot offer answers, when at the present the answers do not exist.

It is our intention to let Washington hear from the veterans of the State of Tennessee. Through your cooperation and understanding we can work more efficiently with you and most importantly for you.

PREPARED STATEMENT OF ROBERT S. BIELAK, DIRECTOR, VETERANS ADMINISTRATION REGIONAL OFFICE, NASHVILLE, TENN.

Mr. Chairman: I would like to welcome you, other subcommittee members participating and members of your staffs to Memphis, Tennessee. I would like to express on behalf of the 250 employees of the regional office, their appreciation for your willingness in bringing your subcommittee to our area to receive testimony on veterans' programs and problems. I am accompanied today by our Adjudication Officer, Mr. Patrick Courtney, and our Veterans Services Officer, Mr. George Henry, who will be on hand to assist me in providing answers to any questions that may arise.

Mr. Chairman, with your permission, I would like to first give you a brief overview of our operations. The Veterans Administration Regional Office at Nashville, Tennessee is one of 58 regional offices in the Department of Veterans Benefits. The Nashville Regional Office has jurisdiction of veterans benefit programs throughout the State of Tennessee. Benefit programs include: compensation, pension, education benefits, home loan guarantees and vocational rehabilitation. With about 250 employees located at Nashville we strive to provide quality service to the 541,000 living veterans in the state (167,000 from the Vietnam era). We like to think that we have been successful in this endeavor in that from time to time operating elements in this office have been recognized for their excellent performance under the Department of Veterans Benefits evaluation system. For instance, just last fall our Adjudication Division was presented a Commendation for high level achievement approved by Chief Benefits Director Dorothy Starbuck.

In terms of workload and beneficiaries serviced, the Nashville Regional Office ranks 22d in size and usually processes about 2 percent of the national workload. Statistical data for Tennessee relating to Veteran Benefits can be found in Exhibit A.

In the regional office we have seven operating divisions. They are:

Adjudication Division processes applications, develops evidence and makes decisions on claims for various benefits, including educational assistance allowance and education loans. Authorizes the payment of awards, and makes appropriate input to compensation, pension and education ADP systems.

Administrative Division provides support service to regional office elements in such functions as mail identification and delivery, establishment of records, file maintenance, control of forms and publications, telecommunication services, centralized transcribing and other services.

Finance Division administers a comprehensive and detailed accounting system for regional office operations including payments to certain veterans and beneficiaries. Conducts a program of payment of administrative expenditure incident to operations, and administers certain collection activities for the regional office.

Personnel Division provides service in all phases of personnel administration including recruitment, placement, training, employee relations and related activities.

Loan Guaranty Division processes applications, develops evidence, and makes determination relating to entitlement to home loan guaranty benefits. Makes appraisal to establish reasonable value, services loans, acquires and disposes of properties, and assists certain physically handicapped veterans who purchase a home with the aid of a grant.

Veterans Assistance Division provides information and assistance to beneficiaries on veterans benefits. Veteran Assistance Division is usually involved where contact is made with the public including: operation of a statewide toll-free telephone network; liaison with educational institutions and an education compliance survey program; conducts field exams and supervises payments to beneficiaries under legal disabilities; and provides public contact service at the

following locations: VA Medical Center, 1030 Jefferson Avenue, Memphis, TN 38104; VA Medical Center, Murfreesboro, TN 37130; VA Outpatient Clinic Substation, Bldg. 6200, Eastgate Center, Chattanooga, TN 37411; VA Medical Center, Johnson City, Mountain Home, TN 37684; VA Medical Center, 1310 24th Avenue, South, Nashville, TN 37203; VA Outpatient Clinic Substation, 9047 Executive Park Drive, Suite 100, Knoxville, TN 37919.

Vocational Rehabilitation and Counseling Division provides a full range of counseling, vocational rehabilitation training and vocational adjustment services to veterans, servicepersons and other eligible persons. These services include educational, vocational and rehabilitation counseling provided by professionally qualified counseling psychologist. Plans programs of education or training to attain established goals, and in instances where personal problems interfere with the successful pursuit of training, help resolve these problems. Assists disabled veterans and servicepersons under Chapter 31 to enter and pursue to successful completion a program of training which will accomplish rehabilitation in the selected objective including special restorative training; similarly assisting Chapter 35 dependents. Also, assists trainees to locate and maintain suitable employment upon completion of vocational training program.

Mr. Chairman, I would like to indicate the degree of participation of veterans and beneficiaries in a few of our major program areas:

EDUCATION PROGRAM

During December 1981, we had 10,844 trainees on the rolls who received $4,696,279.51 in benefit payments.

COMPENSATION PROGRAM

As of December 31, 1981, we had 46,811 compensation cases on the rolls. Payments amounted to $14,143,398.00 monthly.

PENSION PROGRAM

As of December 31, 1981, we had 53,847 pension cases on the rolls. Payments amounted to $9,584,451.00 monthly.

LOAN GUARANTY

During the fiscal year 1981, we guaranteed 2,303 home loans. The principal amount of these loans was $102,818,860.00.

ADMINISTRATIVE

In administering the above programs as well as those of lesser magnitude, we receive and must process a large volume of mail from program participants. For example, during fiscal year 1981, we have received and processed 955,286 pieces of mail.

VETERANS ASSISTANCE

Our Veterans Benefits Counselors provide information and assistance to veterans and beneficiaries through face to face interviews and through our local and toll free telephone service. During fiscal year 1981, we have conducted 51,241 personal interviews and responded to 403,506 telephone inquiries.

TARGET

Target is an automated compensation, pension and education benefits delivery system. The Target system was activated at the Nashville Regional Office in February 1979. At this time both the inquiry and claims processing portions of the system are in operation. For instance, during the first week of February 1982, the Nashville Regional Office processed 25,598 transactions over the Target system. Users of the system are enthusiastic about the system and we are confident that as we gain experience in using the system it should continue to improve job performance and more timely service to VA beneficiaries.

Mr. Chairman, within our regional office, we provide space and office facilities to a number of National and Veterans Service Organizations as well as the Tennessee Department of Veterans Affairs. These offices and their staffs, under powers of attorney, provide advice and assistance to veterans and other beneficiaries in presenting their claims to the agency. They provide a needed service to their members and non-members alike. I might add that they also provide to me and my staff, the type of constructive suggestions for improvements in our operations which serves to improve overall service to our clients. The organizations and the Officer-in-Charge are listed below:

SERVICE ORGANIZATIONS, VETERANS ADMINISTRATION REGIONAL OFFICE, NASHVILLE, TENNESSEE

American Red Cross: Simon Rooks.
AmVets: Roy Beddingfield.
Disabled American Veterans: Donald L. Samuels.
Tennessee Department of Veterans Affairs: David N. Gaither.
The American Legion.
Fleet Reserve Association.
Military Order of the Purple Heart.
Veterans of Foreign Wars of the U.S.
Veterans of World War I of the U.S.A., Inc.

I would like to mention briefly our involvement in assisting veterans in finding employment. As you know, the legal responsibility for assisting veterans in finding employment is placed in the Department of Labor. However, our Administrator has urged that VA Offices provide whatever assistance possible in support of their efforts.

We have a fully functional Career Development Center operating at the regional office. The objectives of the Career Development Center are to provide disabled and other veterans with current career and job information, using not only printed but also audiovisual and, perhaps, computerized materials; training in job-finding skills and approaches; understanding of career development and the place of training in such development; and direct placement contacts or appropriate referral for job placement assistance.

At the Career Development Center micro-fiche which is furnished to the Veterans Administration by the Tennessee Department of Employment Security is used to help veterans find jobs. This fiche contains current job openings available in Middle Tennessee. After identifying potential jobs for which they may qualify, the counselor refers the veteran to an Employment Representative (DVOS) who is assigned to our office. Although our role in this endeavor is not a major one, we believe we are making a needed contribution.

Mr. Chairman, this completes my statement. If there are any questions, I will be glad to try and answer them.

VA REGIONAL OFFICE, NASHVILLE, TENN.—IMPACT ON ECONOMY, FISCAL YEARS 1978-80—SELECTED VETERANS' ADMINISTRATION EXPENDITURES IN TENNESSEE

	Fiscal year—		
	1978	1979	1980
Compensation	$114,436,119	$125,784,934	$140,986,084
Pension	98,189,653	107,324,063	108,081,502
Vocational rehabilitation—Ch. 31 (subsistence, tuition, supplies)	1,436,188	1,415,990	1,243,168
Educational assistance—Ch. 34 (veterans readjustment)	75,064,138	60,767,965	52,364,733
Educational assistance—Ch. 35 (widows and orphans, and wives and children of severely disabled veterans)	3,936,389	3,840,755	3,704,754
Insurance (dividends, indemnities)	13,146,093	16,717,787	17,890,217
Conveyances for disabled veterans (automobiles)	402,878	346,126	334,530
Housing for paraplegics	200,000	403,208	207,817
Direct loans to veterans	259,122	140,051	238,999
Hospital and domiciliary facilities (construction)	2,361,875	3,931,738	9,849,882
Administration and other benefits (medical)	134,452,541	147,433,416	162,055,028
Total of benefits listed	443,884,996	468,106,033	496,956,714

VETERANS' BENEFITS—STATISTICAL DATA FOR TENNESSEE

	As of Dec. 31, 1979	As of Dec. 31, 1980	As of Dec. 31, 1981
Veteran population in Tennessee (approximate)	541, 000	542, 000	541, 000
Total active compensation and pension cases (live and death)	105, 154	102, 833	100, 658
Number pf payees	112, 672	110, 150	106, 834
Live (total)	67, 688	66, 727	65, 855
Compensation (S3)	38, 546	38, 806	38, 992
Pension (old law)	841	695	651
Pension (Public Law 95–588)	5, 477	9, 676,	10, 988
Pension (SEC 306)	22, 824	17, 550	15, 314
Death (paid to beneficiaries) (Total)	46, 282	43, 423	40, 979
Compensation (SC)	10, 308	10, 001	9, 645
Widows	4, 555	4, 666	4, 740
Children	1, 829	1, 674	1, 525
Parents	3, 924	3, 661	3, 380
Pension (old law)	1, 017	954	835
Widows	1, 003	941	822
Children	14	13	13
Pension (Public Law 95–588)	3, 323	5, 383	7, 195
Widows	3, 082	5, 030	6, 687
Children	241	353	508
Pension (sec. 306)	31, 634	27, 085	23, 304
Widows	20, 920	18, 340	16, 189
Children	10, 713	8, 745	7, 115
Average total monthly benefits	19, 488, 317	21, 703, 780	23, 727, 849
Veterans and servicemen in education and training under G.I. bill (chapter 34)	13, 572	11, 621	9, 330
College level	9, 298	8, 082	6, 545
Below college level	2, 962	2, 420	2, 081
Apprenticeship and OJT	1, 312	1, 119	704
Flight training (included in below college level)	203	138	60
Vocational rehabilitation (chapter 31)	197	187	300
Wives, widows and children (chapter 35)	1, 030	1, 084	1, 126

○